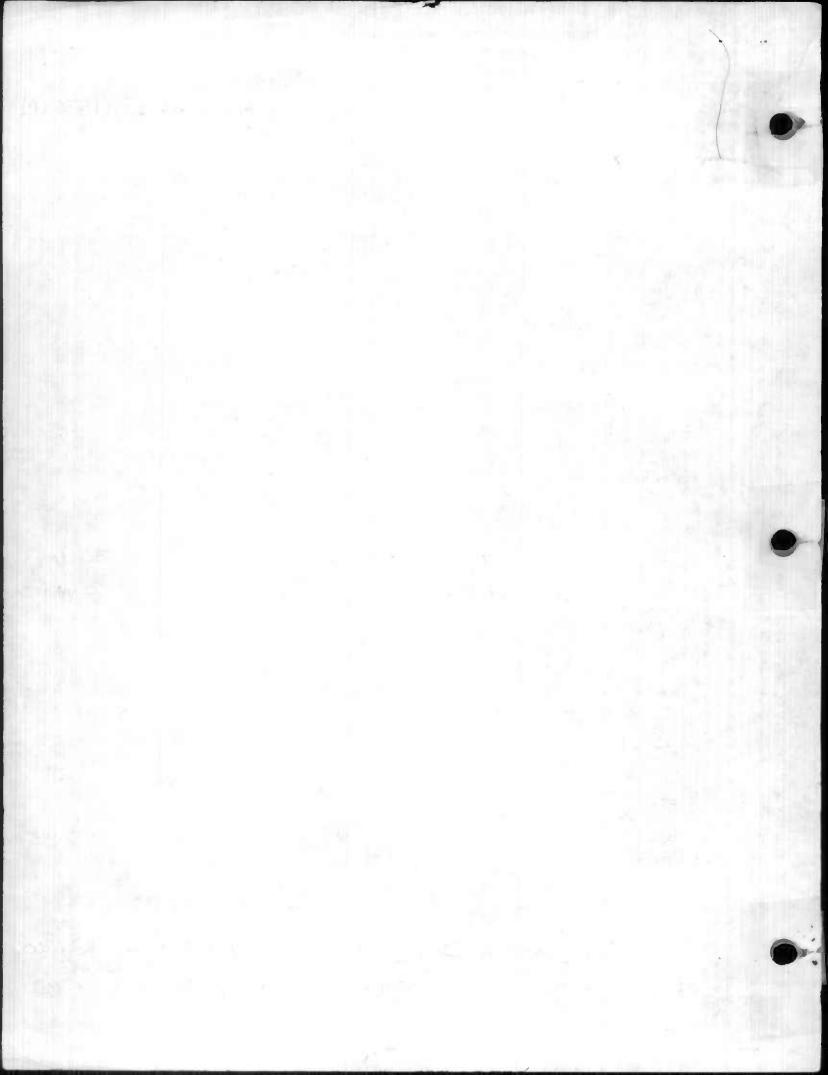
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State of Maryland / Department of Health and Mental Hygiene 00 0950

				Cer	tificate	e of L	Death		Reg. No.			101
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	David	Jone	es					Marc	h 22			30 Pl
4a Facili	ty Name (If not institution, gi	ive street end number)				41			th 4c. Co		ath	
		1 Hospita	al									
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			10c. City,	Town or Lo	cation						10d. Inside	City Limi
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							nd Number or rne Ro	ad Bal			aryla:	nd
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sho	ock, or heart feilura. List onl	ona causa on each in	ne.									Between nd Deeth
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resulting	or condition in death)	a	_	_		0					100	day
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	OPD									24	 b. Were autop aveileble pr complation of death? 	ior to
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25. Was	case referred to medicef						26. Place of D	aath (Check onl	y ona)			-
		Hospital: 1 Inpatie	ent 2 E	R/Outpatier	nt 3 DC	Oth	ar:			☐Othar (S	pecify)	
	per of Death	28a. Data of Inju	ry :	28b. Tima o								
	Accident Investigati	on	, . 541)	пдату	М							
	dotormino	d 286. Place of in	28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)						 Location (Street and Number or Rural Route Number, City or Town, Steta) 			Vum <i>ber,</i>
building, atc. (Specify) City or Town, Stera) 29a. Certifier Descritying Physicien: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated.												se(s)
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296 Sig	•)	and menner st		23a) (Type,	/	47	243	8946 rsity 1	Mo	rch	22	1,20
ı	4a Facili Un 5. Social 21 Usual Re 10a. Stel M 10e. Stre 50 11. Merit 1	David 4a Facility Name (If not institution, gr Union Memoria 5. Social Security Number 215-66-3745 Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 5016 Goodnow 11. Merital Status 1 Never Married 3 Widowed 4 Divorced (Specify only highest gr Elementary/Secondery (0-12) 4th Grade 17. Father's Nema (First, Middle, Las William 19a. Informant's Name/Ratationship Loretta Cha 20a. Method of Disposition 1 XBurlel 2 Cremation 3 4 Donetlon 5 Other (Special Contents) 21. Signature of Funeral Service Lice 22a. Part. Enter the disease, or conshock, or heart feilura. List only Immediate Cause (Final disease or condition resulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Part II. Other significant conditions 1 Neturel Service Lice 2 No 27. Manner of Death 1 Neturel Service Conditions 2 No 27. Manner of Death 1 Neturel Service Conditions 3 Suicide 6 Could not	4a Facility Name (If not institution, give street end number) Union Memorial Hospita 5. Social Security Number 215-66-3745 15. May 2 F 10a. Stete 10b. County MD NA 10e. Street and Number 5016 Goodnow Road Apt 11. Merital Stetus 1 Never Married Merried 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Ath Grade 17. Fathar's Nema (First, Middle, Last) William Harrie 19a. Informant's Name/Ratetionship (Type, Print) Loretta Chandler 20a. Method of Disposition 1 Mauriel 2 Cremation 3 Removal from State 4 Donetton 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22a. Part 1. Enter the disease, or complications that ceuse shock, or heart feilura. List only one cause on each in the cause (Final disease or include the presulting in death) Sequantially list conditions, if any, leading to immediate cause (Disease or inlury that initiated avants resulting in death) Last Part II. Other significant conditions contributing to death be cause (Disease or inlury that initiated avants resulting in death) Last 25. Was case referred to medicef examiner? 1 Yes 2 No 27. Manner of Death Neturel Silpending and Cause (Disease or inlury that initiated avants resulting in death) Last 28a. Data of Injury (Month), De 28a. Place of Injury (Month), De 28b. Place of Injury (Month), De 28b. Place of Injury (Month)	David Jones 4a Facility Name (If not institution, give street and number) Union Memorial Hospital 5. Social Security Number 215-66-3745 Usual Residence of Decedent 10a. Stete 10b. County NA 10c. City, Ba. 10b. Street and Number 5016 Goodnow Road Apt. "D" 11. Merital Stetus 1 Never Married 3 Widowed 4 Divorced 12. 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City, Town or Location Baltimore 10d. Street and Number 5016 Goodnow Road Apt. "D" 11. Merital Status 12. Was Decedent Ever in U.S. Amed Forcest Town or Location 11. Merital Status 12. Was Decedent Ever in U.S. Amed Forcest Town or Location 12. Merital Status 13. Was Decedent of Hispenic Origin? 14. Wes Specify Colber, 16. Specify 15. Decedent's Education (Specify only highest grade accompleted) 15. Decedent's Education (Specify only highest grade accompleted) 15. Decedent's Lysal Cocupation (Specify only highest grade accompleted) 15. Merital Status 15. Merit	As Facility Name (floror institution, pive street and number) Union Memorial Hospital 5. Social Security Number 215-66-3745 \$\frac{9}{2}\text{M}\text{2} = \frac{7}{2}\text{Age (fir yrs. hast birthday)}} Unider 1 Year In Under 2 His 8. Dies of 8 Dat 1 Mortins Days Min. 100. Colly Mortins Days Mort	David Jones 4a Facility Name (Inci institution, pive street and number) Union Memorial Hospital 5. Social Security Number 215-66-3745 5. Sex 21	David Jones Morth Pay A 200 46. Flexy, Town, or Location of Death Union Memorial Rospital 5. Social Security Number 215-66-3745 Security Number 215-66-3745 Security Number 106. Serv 107-860 Security Number 107-860 Security Number 108. Security Number 109. Security Number 109. Security Number 109. Security Number 100. Security Numb	David Jones David Jones 46 CRy, Town of Location of Death As Facility Name (Fine Institution, pive storest end number) Union Memorial Hospital 5. Social Security Number 215-66-3745 David Time Institution 105 County 105 CRy, Town of Location 106 County 107 Age (fiv yrs. last Netherlay) 106 CRy, Town or Location 107 Age (fiv yrs. last Netherlay) 107 Age (fiv yrs. last Netherlay) 108 Age of Bioman 109 Citizen of What County 109 Citizen of What Coun



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09502. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Charles F. March 24 2000 7:15 AM Kampe, Sr. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7856 Catherine Avenue Pasaderia H Under 24 Hrs. Hours | Min. Sept. 2, 1918 Pasadena Anne Arundel If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 81 Yrs. 217-09-8171 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7856 Catherine Avenue 21122 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Carpenter Supervisor Carpentry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles Frederick Kampe Lillian Mae Biggar 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen K. Kampe - Wife 7856 Catherine Avenue, Pasadena, MD 21122 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Slen Haven Cemetery March 27 Glen Burnie, MD 22. Name end Address of Facility Stallings Funeral Home, PA 21. Signeture of Funeral Service Licens 3111 Mountain Road, Pasadena, MD 21122 23a. Part . Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line. Do not enter the mode of dying, such es cardiec or respiretory arrest, Approximate Interval Between Onset and Death 3mo Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 20 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

be executed

P.O. Box 68760,

Records.

permit. Pages 1 and 2 should be fill Department of Health and Mentel Hy Important: If Item 27 Ia marked oth any Injury or other traumatic avan

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

il Hygiene, other than 'natural', or floms 23a or 28a-f show vant, the Medical Examiner must be notified at

death

filed within 72 hours efter

altimore, Maryland 21215-0020

attending physician and for use as the burial-transit signed by the a certificata this After

Examiner Physician/Medical þ Completed 8

Division of Vitai or Attanding Physician: edical Certification: To after death. in by To the Hospital o within 24 hours aft To the Funeral Di completaly filled in

State Registrar

MAR 2 4 2000

27. Menner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

+ Neturel

5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 Yas 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year)

Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Hem 23st) (Type Print)

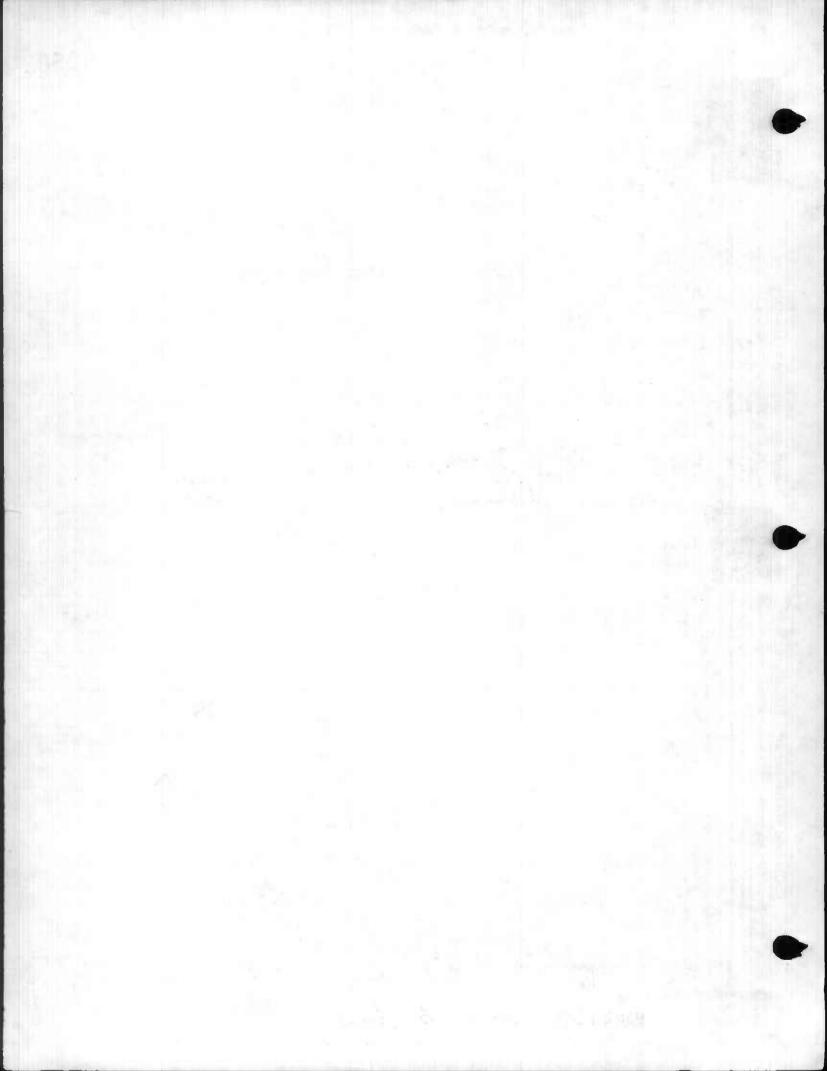
31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2. Registrar's Signeture

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death Day 2000 March 22, **Physician** Nellie Maude Koose 9:00 p.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Manor Inc.
5. Social Security Number 6. Sex Lutherville Baltimore If Undar 1 Yaer | If Undar 24 Hrs. | Months | Devs | Hours | Min. | 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Deys 1 M 201 F Director 366-07-6532 June 9, 1907 Tennessee Usual Rasidence of Decede r 28a-f show 10a Stata 10b Counts 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 TNo Md. Baltimore Lutherville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be or Reme 23s U.S.A. 300 West Seminary Ave. 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yas 2 Ø No If Yas, Giva Yaar or Datas: 11. Maritel Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian. r than "natural", or han the Medical Examiner. Black, White, etc. 1 □ Nevar Married 2 □ Married Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygians. Hygians. other than 'n Elemantary/Secondary (0-12) College (1-4or 5+) 12 Clothing Seamstress 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) 12 should be 11 h and Mental H I is marked off Be Steven R. Webb Eula Mae Warren permit. Pages 1 and 2 sh Department of Health and Important, if hen 27 is m any Injury or other traum. 00026. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) 106 Old Padonia Road Hunt Valley, Md. Richard M. Cole 21030 Baltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 M Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Evergreen Mem. Gardens March 27, 2000 Finksburg, Md. 22. Nama and Address of Facility
Eckhardt Funeral Chapel 21. Signature of Funarai Sarviçe Licenses intar 11605 Reisterstown Rd. Owings Mills, Md. 21117 Part Vinter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heer feiture. List only one cause on each line. Approximeta Interval Batwaan Onsat and Death Physician Immediata Causa (Final disaase or condition rasulting in death) /Medical **Examiner** Examiner bunal-transit Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as e consequença of): and Box 68760. attending physician for use as the burie certificate be Physician/Medical Dua to (or as e consequenca of): P.O. Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? the 1 Yss 2 PNo 3 Probably 4 Unknown signed by Division of Vital Records. by 24b. Wera autopsy findings evailable prior to completion of cause of death? 24e. Wes en autopsy performed? Completed peed page 2 certificate has 2 18 No t ☐ Yas 2 PNo 1 ☐ Yes 25. Was casa refarred to medical axaminer? Be 26. Place of Death (Chack only one) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 20 No To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner_of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After 1 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 ☐ Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 2 4 | Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signatura and title of cartifiel 29c. License number 29d. Date/signed (Month, Day, Year) ND 00 605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite Joseph A. Adams, M.D. 6565 N. Charles St. GBMC East Pavilion Towson, Md. 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 4 2000 Registrar

DHMH 16 Rev 6/95

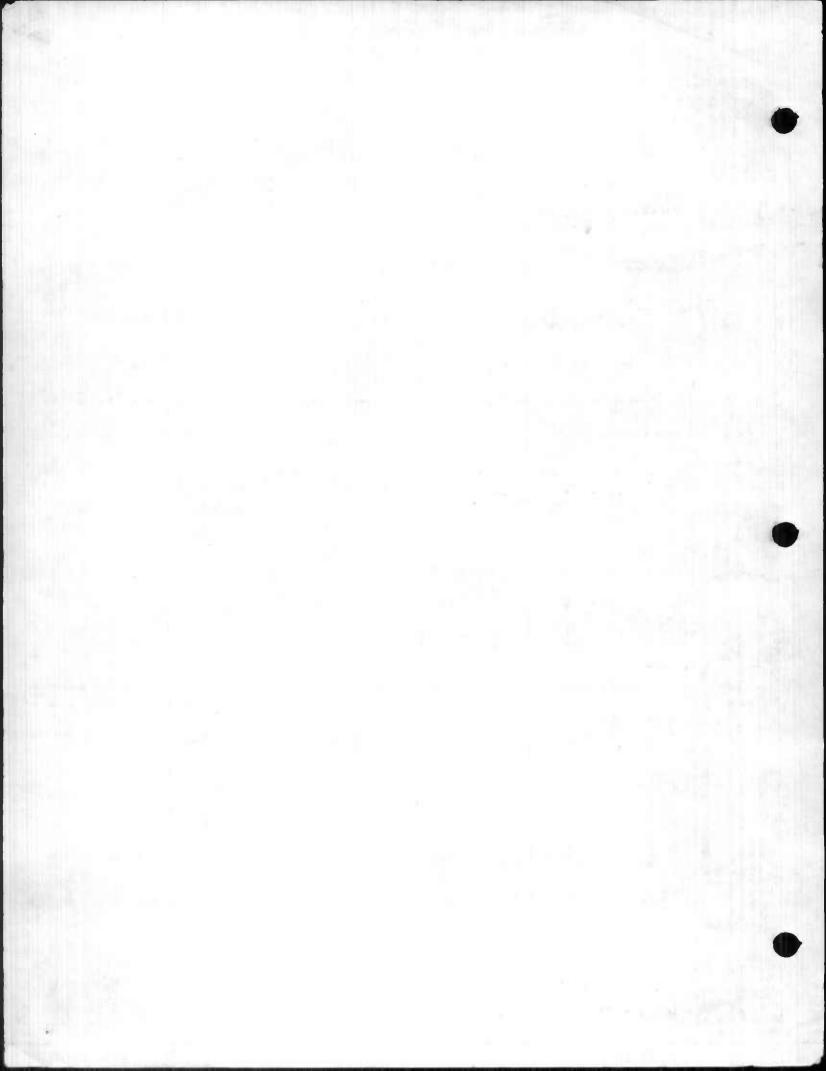
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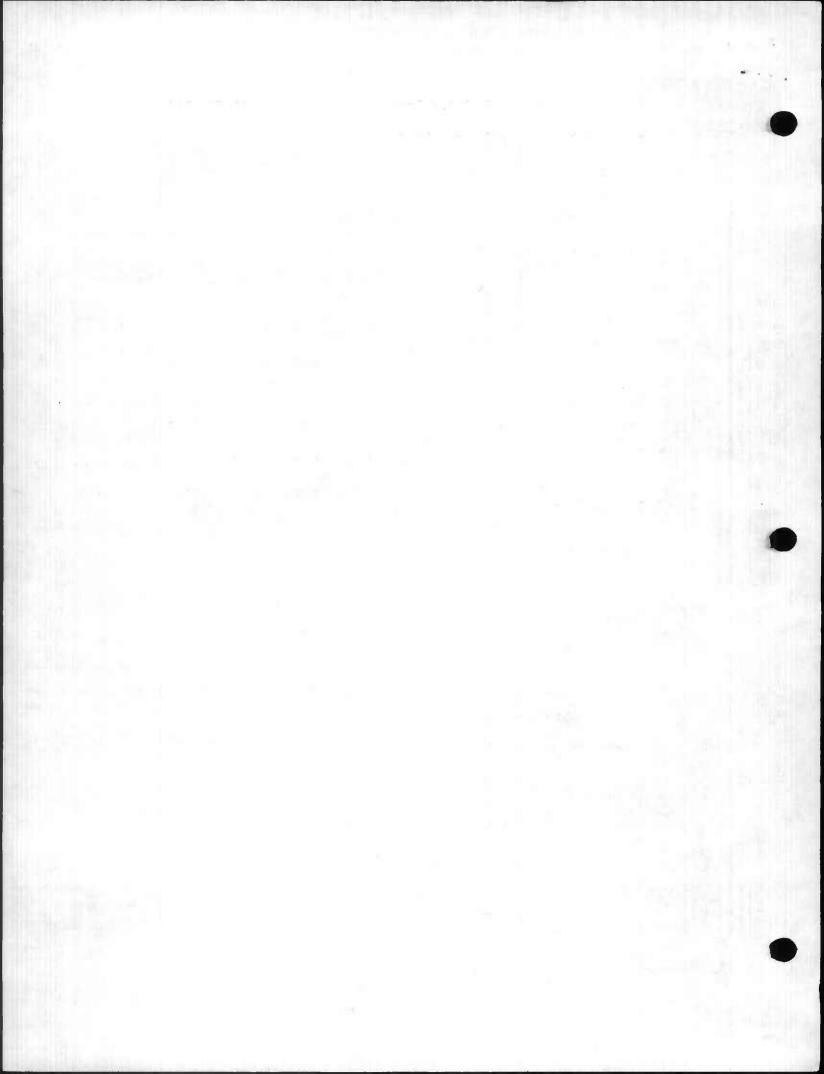


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State of Maryland / Department of Health and Mental Hygiene

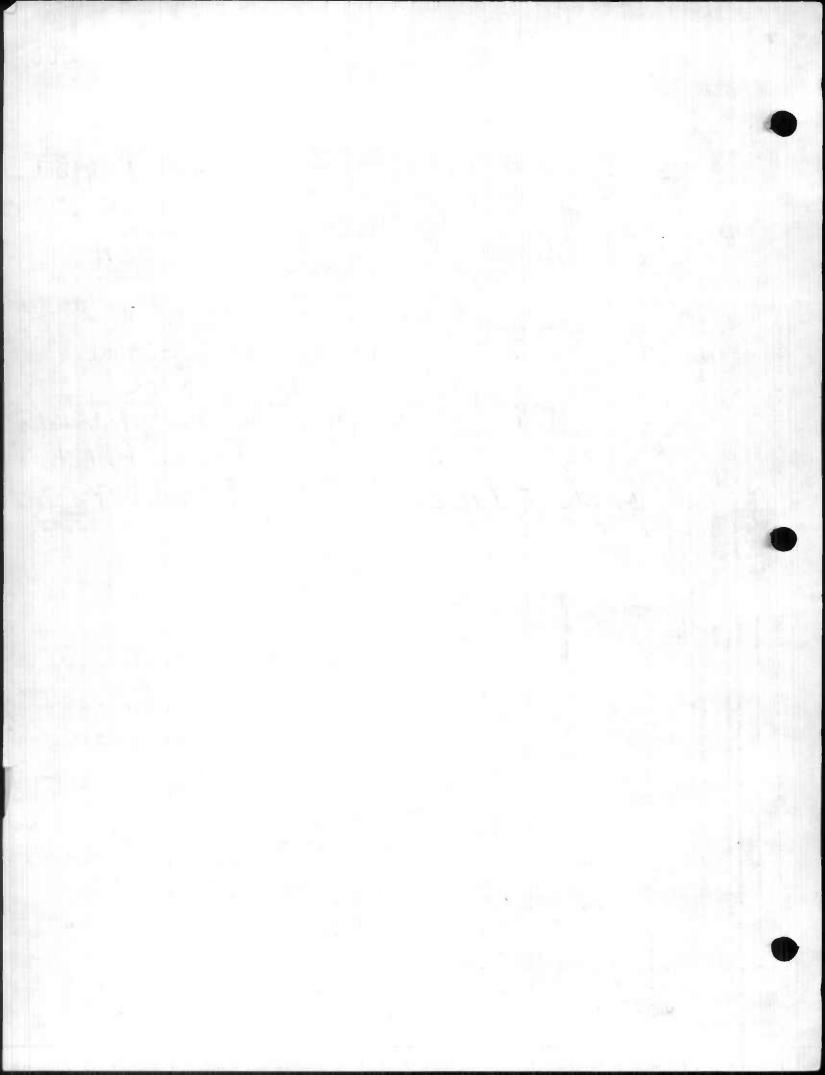
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-			Cer	tificate of	Death		Reg. No.				
	1. Decedent's Neme (First, Middle, L	ast)				2. Date of De			3. Time of Death		
Physician	Anna Mae Leimkiinler 103 17 2000 111.47 a										
/Medical Examiner	4a Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of Deat	7	of Death	11.47 am		
Examiner	Howard County		pital		Columbi	a					
		Sex 7. Age (In yrs.	-	If Under 1 Year			Howa		ace (State or Foreign		
Funeral Director	Control of the contro	1 M 2DLF	Yrs.	Months Days	Hours Mir	. (Month, De	y, Year)	Counti	(y)		
Director	215-16-0818 Usual Residence of Decedent	78				08 08	1921		1d		
D R	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10	d. Inside City Limits		
or all	Md Howar	cd E	llicot	+ Ci+++					1 ☐ Yes 2 PNo		
th the Marylan or 28a-f show a notified at Ninector	10e. Street and Number	Lu E	ITTCOL	10f. Zip Code			10- Chines of W	to a Count	-0		
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UZO um atter death with the Maryla iii; or flams 23s or 28s-f sho Exerciper must be notified at by Funeral Director	JUU4 N KIUge Koat	•									
r de	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I,S. 13. V	Ves Decedent of his Yes, specify Cub.	lispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race Black	- America k, White, e			
5-0020 72 hours after natural; or th sign! Examin		1 Yes 2 No	1	☐ Yes 2 No	Specify:		Specify:	T 77			
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I 21215-0020 ed within 72 hours at viglence. ver than "natural", or ver than "natural", or it, the Medical Exami Completed by F	15. Decedent's I (Specify only highest g	Education rade completed)	16a. Deced	lent's Usual Occup	etion during most of w	orkina	16b. Kind of Bu	siness/Indi	ustry		
No. of the Party No.	Elementery/Secondary (0-12)	College (1-4or 5+)		kind of work done OO NOT use retire	d)						
	12		Homer	maker			Own	Home			
Maryland 2 should be file th and Mental Hy 7 is merked othe traumatic event	17. Father's Name (First, Middle, Las	·				me (First, Middle	Maiden Surnami	1)			
/lan		2			Agnes	Wolf					
and	19a. Informent's Name/Relationship	(Type, Print)	19b. Meilin	g Address (Street	and Number or F	Rural Route Numb	er, City or Town,	State, Zip I	Code) 21043		
E 22 OK 66	Urban Leimkuhler	husha	300	4 N. Rid	e Rd A	nt 202 E	llicott	City			
of Har and a state of the state	20a. Method of Disposition	20b. F	Plece of Dispos	sition (Name of		Data	20c. Location -				
Baltimore, semit. Pages 1 a Department of Hes reportant: If Nem my Injury or othe otics.	1 ■ Buriel 2 □ Cremation 3	Hemoval from State		natory or other pla							
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Department of the state of the	21. Signature of Funeral Service Lice	1 /		. Name and Addre		1 1 5	1 11				
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ilan: The still calls or the still calls or the calls. De Co	25. Was case referred to medical				26 Place of De	eath (Check only					
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	one)	and manner steted.					and and preco, e				
Total Maria	29b. Signature and titla of certifier			29c. Licens	e number		29d. Date signed	(Month, D	Day, Year)		
/1	Holendo h	Ash makey.	mp	0	04832		morres	4 2	vo. 2000		
X	30. Name and addrass of person who	complated causa of death (Item	n 23a) (Type, i	Print)							
0	ROLENDO 1	7. SABUN	nago.	mp	Pa						
State	31. Data filed (Month, Day, Year) MAR 2 4 2000	Registrar's Signa			+						
Registrar	MAR 2 4 2000	A STATE OF THE STA	N. 1	yours!							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. WVL State of Maryland / Department of Health and Mental Hygiene 09506 00-1507-510 Certificate of Death Theodore Logan 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 14,2000 Month **Physician** March 8:45 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Shock Trauma Baltimore If Under 24 Hrs. # Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 213-27-2869 Usual Rasidanca of Dacedent 10 M 20 F Yrs. Director the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show mant be notified at 1 Yes 2 No Director Naryland more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe d Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 12. Was Decedent Ever in U,S Armed Forces? Race 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: 1 Nevar Married 2 Married 21215-0020 1 Yes 2 No Specify: py 3 ☐ Widowed 4 ☐ Divorced Hmerica. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heelth and Mental Hygiene Important: If frem 27 is marked other that any fulury or other traumatic event, if a blace. altimore. Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be rendore 19b. Mailing Address (Street and Number or Rural Route Number, City or To 19a, Informant's Name/Relationship (Type, Print) n. State. Zip Code) (mother 242 CVI. 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Buriai 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 22. Name and Add OSED W. Nor tue. Approximation of the Conset and Death of dying, such as card **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last pue Dua to (or as a consequence of): physician a 68760 Physician/Medical the Due to (or as a consequence of) affending for use as Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobecco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 1 Yes 2 No NO Yes 2 No certificate Division of Vital Attending Physician: director, Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yas 2 No edical Certification: To Conpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred the Drotten CAN 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Panding Invastigation Injury 1 Natural death. 1 Yes 2 10 PASSOMER IN CARCOLISIO 0000 2 Accidant Director: / -14-00 3 Suicide 6 Could not be datarmined 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At homa, farm, street, factory, office building, etc. (Specify) hours after 4 | Homicide 6 2400 DOMSONSTKATINO REMO DADWA To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, feath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signatura and titla of certifiar 29d. Data signed (Month, Day, Year) 3-16-00 O.C.M.E. 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) MARysmon (4) Novel 11 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Day Year) 32. Registrar's Signatura State Registrar



amend item 23a,27,28a,b,c,d,e,f, per me G782 4/11/00 yg

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Certificate of Death	Den No	00	0 2 0 1

RT LEE	?		State of W	iai yiai ic		tificate			- Wiental H	Reg. No.	10	09507.	
Pi	hysician	Decedent's Name (First, Middle, Last)							2. Date of Di Month	Day	Year	3. Time of Deeth	
	/Medical	ANDRE ROBERT	LEE					D. Ch. Tarin	MARCH 20, 2000 or Location of Death 4c, County of Death			16:15 PM	
£ E:	xaminer	4a Facility Neme (If not institution, g 3 STOCKMILL ROAD					1	RANDALI			IMORE		
Fu	deeth with the Menyland THE 286 or 286-4 show The ment be mouthed at	5. Social Security Number 6.	. Sex 7. A	ge (In yrs. la	st birthday)	If Under		If Under 24 Hi	s. 8. Dete of Bi			lace (Stete or Foreign try)	
Dire		217-64-6199 X Usual Residence of Decedent	M 2□ F				Days	Hours Mi	9/6/5	ay, Year)		IMORE, MD.	
ylend		10a. State 10b. County		10c. City,	Town or Lo	cation					1	Od. Inside City Limits	
Me Me		MD. BALTIMO	RE	RA	NDALLS	STOWN						1 Yes 2 No	
vith th		10e. Street and Number	1 1 777 0			10f. Zip				10g. Citizen of	What Coun	try?	
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- 3 2	Example must	1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces XXIX Yes 2 If Yes, Give Year or Dates	No		Yes, spec			(Specify Yes or Norto Rican, etc.)	Ble	ck, White,		
-00 Hour	9	15. Decedent's		8/85	16a. Deced	lent's Usua	Occur	ation		16b. Kind of B	usiness/inc	lustry	
Baitimore, Maryland 21215-0020 John Pages 1 and 2 should be filed within 72 hours after Poperment of Health and Mental Hygiene.	went, the treatment of the Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	5+)	(Give life. L	kind of wor DO NOT us LITAR	k doné d e retired	during most of w	orking				
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lid be	important: It from \$7 is marked other the any injury or other treumetic event, that longs. To Be Com	JONNIE BANNERMA	N JOHNNIE	1				EMMA	WILLIAM	BANNERM	IAN		
ary and N	E	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street	and Number or I	Rural Route Numb	ber, City or Town	State, Zip	Code)	
1 and 2	4	CLFO LEE WIFE			3STOCK MILL ROAD, APT				T. E. RAN	DALLSTOU	IN, MI	21208	
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Baitim pemit. Pag Department	(a)	4. Donation 5 ☐ Other (Special Service Lie	cify)	GA	RRISON	V.A.	CE	METERY	3/27/00	OWINGS	MILL	S, MD.	
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of Vita Physicien:		examiner?	Hospital:	ient 2 🗆 E	R/Outpatien	t 3□ DO	Oth		Home 5XXHes		ner (Snecih	v)	
On of ding Phy		27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, De	ay Year)	28b. Time of		c. Injun			how injury occur			
Division or Attachment of the Country of the Countr	ed in by the funeral Certification:	3 Suicide 6 Sould not determine	28e. Place of In building, e	jury - At hon tc. (Specify)	ne, farm, str			AX.	City or To	28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Stockmill Road			
DIV	lataly fills	found: residence Randallstown, Md. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to and manner steted.											

State Registrar

A. KORTLE 31. Date filed (Month, Day, Year) MAR 2 4 2000

ed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

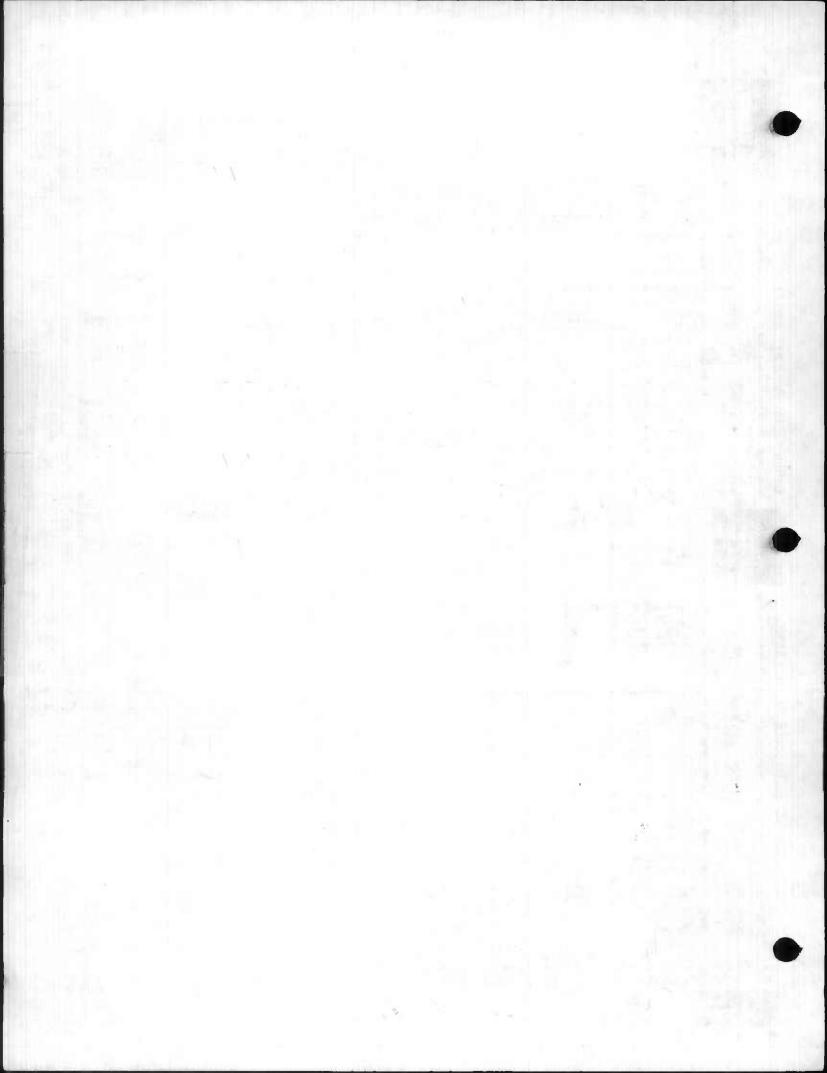
29d. Date signed (Month, Day, Year)

MARCH 21, 2000

DHMH 16 Rev 6/95

29c. License number

O.C.M.E.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Joseph Martin Lightner March 17, 2000 9:42 pm 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Franklin Square Hospital Faltimore County
Under 24 Hrs. 8. Dete
Hours Min. (Mon Baltimore If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) 1□ M 2□ F Months Vrs 212 28 2249 70 October 13, 1929 Baltimore, Maryland X Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore County Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5031 Hilltop Acres Road 21128 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stafus 14. Reca - American Indian, Bieck, White, etc. 1 ⊠ Yes 2 □ No
If Yes, Give
Yeer or Detes: 1948–1952 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiamentary/Secondary (0-12) Coilege (1-4or 5+) 12 Musician Entertainment Industry 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Martin John Lightner Anna Elizabeth Seufert 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Name/Relationship (Type, Print) Martin J Lightner (Son) 27 Shrewsbury Ct. Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Buriei 2 □ Cremation 3 □ Removei from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem. March 21, 2000 Baltimore, Maryland 21. Signeture of Funerei Service Licenses 22. Name end Address of Fecility Lassahn Funeral Home 23a. Part1. Entar tha dise or complications that cause 3 to deeth. Do not enter the mode of dylng, such as cardiac or respiretory shock, or heart failura. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236 Approximate Intarval Batween Onset and Deeth Immadiete Cause (Final disease or condition resulting in death) Due to (or es e consequença of): Due to (or es e consequenca of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco uea contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings avelleble prior to complation of cause of deeth? 24a. Was an autopsy performed? of the palatte t ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA

Physician /Medical Examiner

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in 24 hours after death.
The Funeral Director: After the funeral place of the funeral of the fun

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Hospital

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Certification: To

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or Attending Physician: The law requires that the death cartificate be executed

Box 68760.

P.O.

Division of Vital Records,

permit. Pagas Department of Important: If It any Injury or o

Physician

/Medicai

Examiner

10a. State

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Funeral

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Funeral

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al Hygiena. I other than "natural", or items 23a or 28a-f show event, the Medical Examination must be notified at

Pagas 1 and 2 should be filed within 72 hours after death with in and health and Mental Hygiene.
Intel flem 27 is marked other than "natural", or flems 23a or it was or other transer.

Baltimore, Maryland 21215-0020

the Maryland

Examiner Sequentielly list conditions, if eny, leeding to immediata cause. Enter Underlying Ceusa (Disease or Injury that initiated evants resulting in deeth) Lest Completed by Physician/Medical

pothymodism

25. Wes case rafarrad to medical axaminer? 1 Yas 2 No

27. Manner of Deeth 1 Natural

5 Panding investigation 2 Accident 6 Couid not be determinad 3 Suicide 4 | Homicide

28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Hype. Print) Rd. Balt. MD 21234

Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29e. Certifier

1 Certifying Phyeician: To the best of my knowledge, daeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end plece, and dua to the ceuse(s) end menner steted. 29c. License number

29b. Signeture end fitte of cartifier

Kamal

30. Nama and address of person who complated cause of deeth (Item 23e) (Type, Print)

Kamal

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28b. Time of

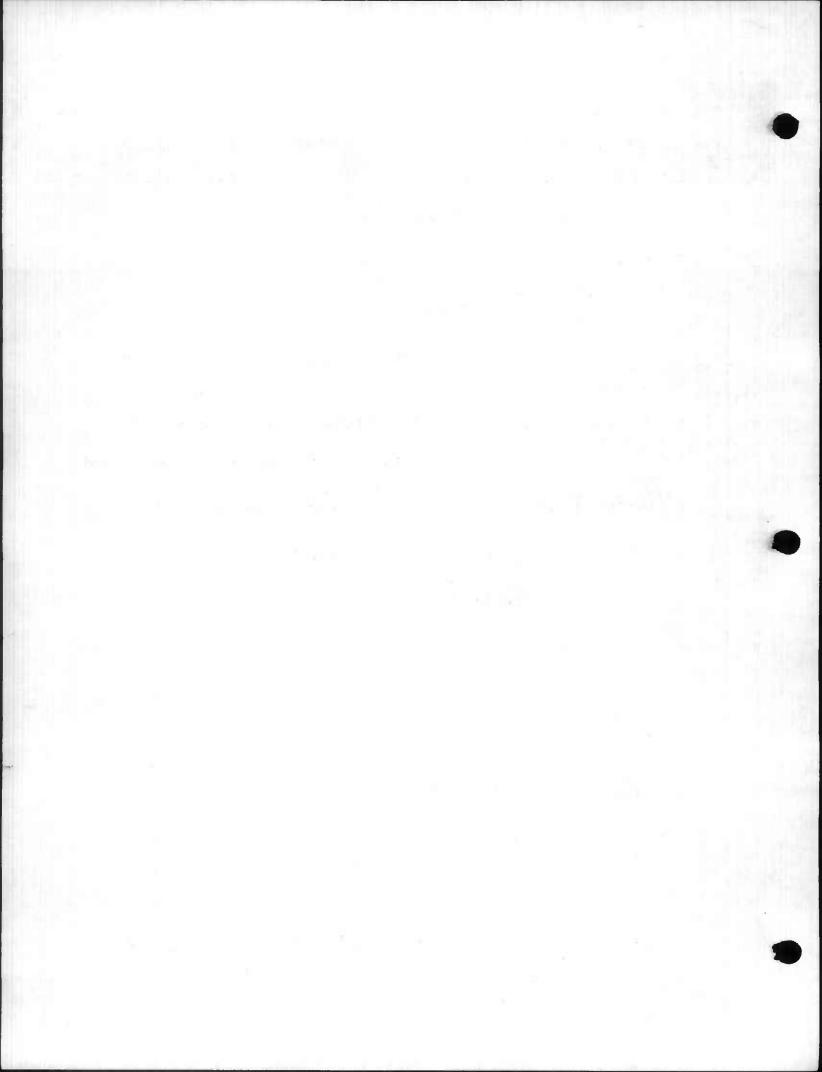
D00 39788

29d. Date signed (Month, Day, Year)

9512 100 Moistrers Significant

28e. Deta of Injury (Month, Day Year)

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Defe of Deeth 3. Time of Death Dey Month **Physician** TERESA CURLEY 11:05 A.M. LAMDIN 18, 2000 March /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Long Green Center Baltimore If Under 24 Hrs. Hours | Min. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1□ M 2♥ F Months Deys Yrs. 90 Director 219-34-0247 Maryland Usual Residence of Decedent 10e. Stete 10c. City, Town or Location 10b. County 10d. Inside Cltv Limits 28a-f show must be notified at 1 ☐ Yas 2 No Director Arlington Maryland Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 P.O. Box 10255 flams 23a 22210 U.S.A. by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Race - American Indian, Bleck, White, etc. 11 Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Hygiene. ther than "natural", or them not, the Medical Examiner. should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Mental marked F. Harry Curley Ida Thomas Margaret 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is n any injury or other traus David Lamdin P.O. Box 10255 Arlington, Virginia 22210 (son) Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 № Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3+21-2000 Parkwood Cemetery Baltimore, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Pert1. Enter the digeese, of complications that caused the deefh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximeta tritervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Neumo viti day Examiner Due to (or as a consequence of) Physician/Medical Examine pug Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated executions) Due to (or es e consequence of) be exec the burtal Box 68760 attending physician thet initieted events resulting in death) Last Due to (or es e consequenca of) ï P.O. Part II. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en europsy performed? this conficate has page 2 Da befelletin 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 48 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1-Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / d in by the f 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Illed in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) and mannar as stated.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 29b. Signiflure and title of or 29c. License number OGOS 22

Registrar

State

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repose Are 21212

age and address of person who completed cause of deeth (Item 23a) (Type, Print)

MD

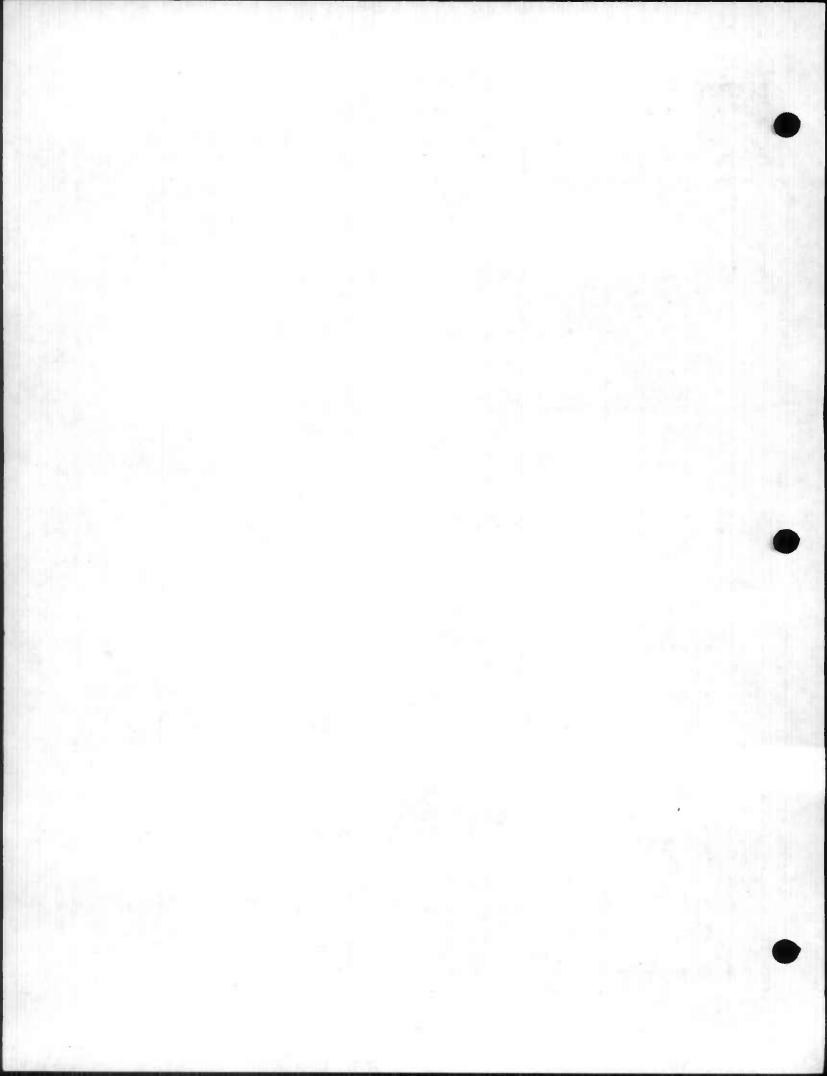
32. Registrer's Signeture

John ARTZ

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MAR 2



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth **Physician** Manne 0539 02 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (ff not institution, give street and number Examiner Medica Baltimore NIA University of Man System If Under 1 Yeer | If Under 24 Hrs. | 5. Social Security Number Birthplace (State or Foreign Country) & Say 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2□ F Yrs. 53 212-44-3994 Maryland Director June 15. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or frams 23a or 28a-f show edical Examiner must be notified at the Maryti 1 Yes 2 No Baltimore. Baltimore Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21237 U. S. A. 930 Chesaco Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Meritel Status filed within 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beer Distributor Driver (Salesman) 11th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) peamit. Pages 1 and 2 should be lit.
Department of Health and Mental Hi important: if then 37 is marked oth any figury or other traumatic even other. Marie T. Soul John L. Mannel 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lorraine L. Mannel (Wife) 930 Chesaco Avenue, Baltimore, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Green Mount Crematory 3/22/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee Mais Maryland 21213 3331 Brehms Lane, Baltimore, ilications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, and cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart fellure. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical neumonia Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence ot): ed by the attending physician detached for use as the buria Due to (or es a consequence of) signed by it by edical Certification: To Be Completed

Division of Vital Records, P.O. Box 68760. After this certificate Physician: To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Part II. Other eignificant conditions co	1 1 1		23b. Did tobacco use contribute to the cause of						
				per	es an autopsy normed?	24b. Were autopsy findings available prior to completion of cause of death?			
25. Was case referred to medical			26. Place of D	eeth (Check only	y one)	9			
exeminer?	Hospital: Impatient 2	ER/Outpatient 3	Home 5 □ Re	ne 5 Residenca 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describ	28d. Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Injury - At he building, etc. (Specif	ome, farm, street, fac y)	28f. Location City or T	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	reician: To the best of my kno iner: On the basis of examine and manner stated.								
29b. Signature and title of certifier			29d. Date sign	ed (Month, Day, Year)					

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State Registrar

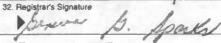
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31. Date filed (Month, Day, Year)

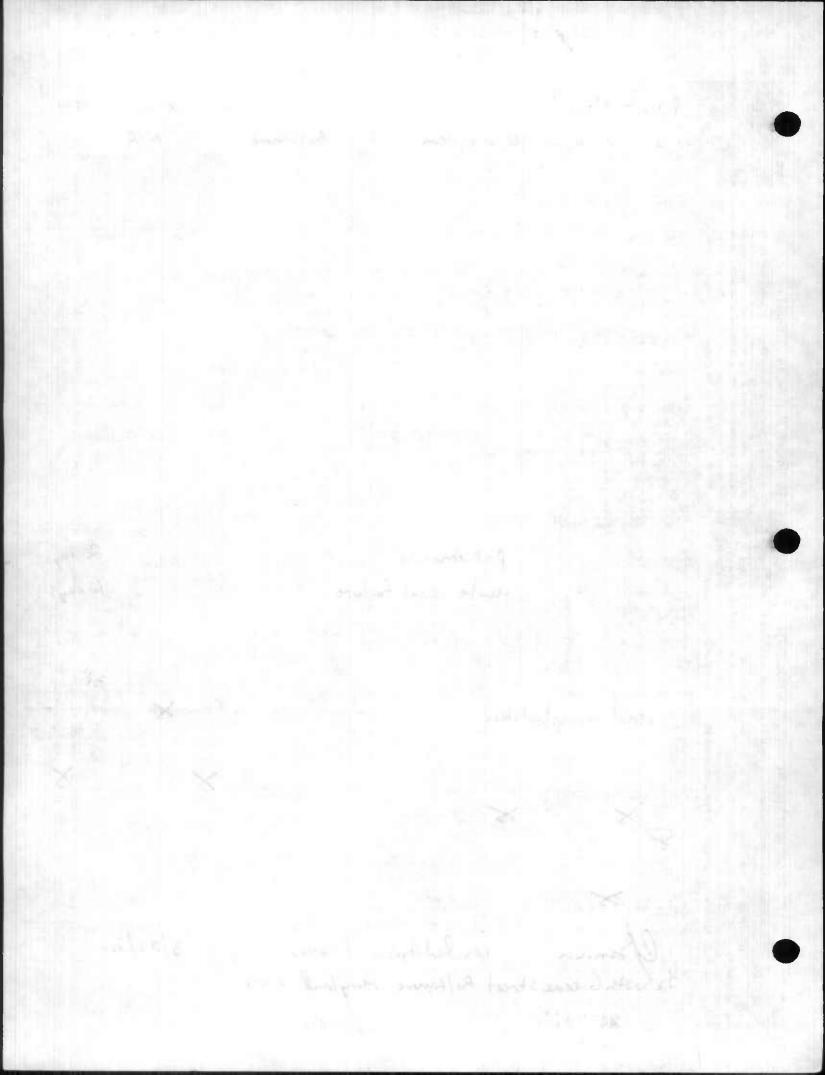
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street



BA

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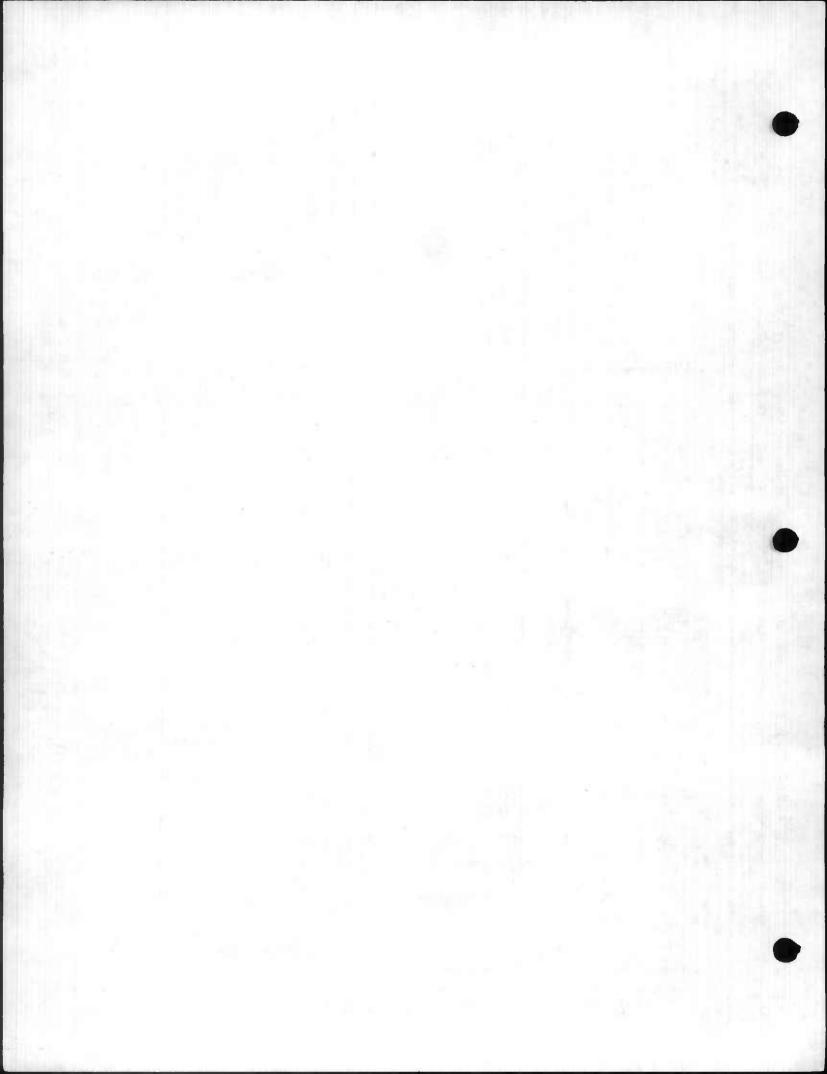
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State of Maryland / Department of Health and Mental Hygiene

09510 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 5:00pm **Physician** 11. MARGARET BARBARA LINDENBERGER 2000 MARCH /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 926 S. HIGHLAND AVE. BALTIMORE If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2√F 96 212-03-6633 Yrs. MAR. 30, Director 1903 MD. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Director MD. N/A BALTIMORE X□ Yas 2□ No 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? 23a or 926 S. HIGHLAND AVE. 21224 USA death Funeral 'natural', or items 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: WHITE à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR TELEPHONE 6TH 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe eny Injury or other treumatic event aloss. Be HENRY UNKNOWN ELIZABETH SCHAEFER 19e. Informant's Name/Relationship (Type Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY DIBARTOLO/NIECE 5657 CALEDONIA DRIVE, SALISBURY, MD. 21801 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State HOLY REDEEMER CEM. 3/15/00 BALTIMORE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Fecility CHARLES S. ZEILER & SON, INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. BALTIMORE, 21224 MD Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel 20 years arten disease or condition resulting in death) OronaRI Examiner Due to (or as e consequence of): TRNSON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): W.CAT attending physician for use as the buria Cholesterolem 12 Physician/Medical Due to (or as a consequence of): athyroidi Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 2 3 Probably 4 Unknown signed i Records, þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 25. Wes case referred to medical axaminer? 20 No Division of Vital Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Dea 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Hospital or Attending i 24 hours after death. Affer 1 Neturel 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: , 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) 5505 HOPKING BAYVIEW CIRCLE BATTIMORE, MI CHRISTINE CHANG, State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 09512 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Milne **Physician** Bruce 2000 8:50AM March /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's Regional Hospital Laurel Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months 10XM 20 F Yrs. 152-28-7227 **Director** Dec. 15, 1937 New Jersey Usual Residence of Decedent deeth with the Meryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rithan "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Directo Maryland Prince George Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 715 Main Street #5 20707 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 DNo If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after class of Health and Mentel Hygiene.
Int. If Item 27 le marked other than "natural", or the iny or other traumatic event, me lead on Early has 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Courier Transportation 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be John Milne Catherine Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jules Bricker/Administrator 966 Hungerford Drive Ste. 26B Rockville, MD 20850 20b. Place of Disposition (Neme of cemetery, cremetery or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Buriel 2 □ Cremetion 3 □ Removel from Stete
4 □ Donation 5 □ Other (Specify) artiment or artistic l' Ft. Lincoln Cemetery 3/21/00 Brentwood, Maryland 22. Name end Address of Facility 21. Signature of Funeral Fleck Funeral Home, Inc. 7601 Sandy Spring Road 20707 Laurel, MD , or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical days Immediate Cause (Final Septeemia diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner days MRSA that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): attending ph Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown ahune P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy s certificate hes I 1 Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifica director, Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Top 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2 4 Homicide A 24 hour. The Funeral Directified in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Fune completely fil 29a. Certifier edical 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number dyviale 53411 March 14th, 2000 MD

31. Date filed (Month, Dey, Year) MAR 2 4 2000

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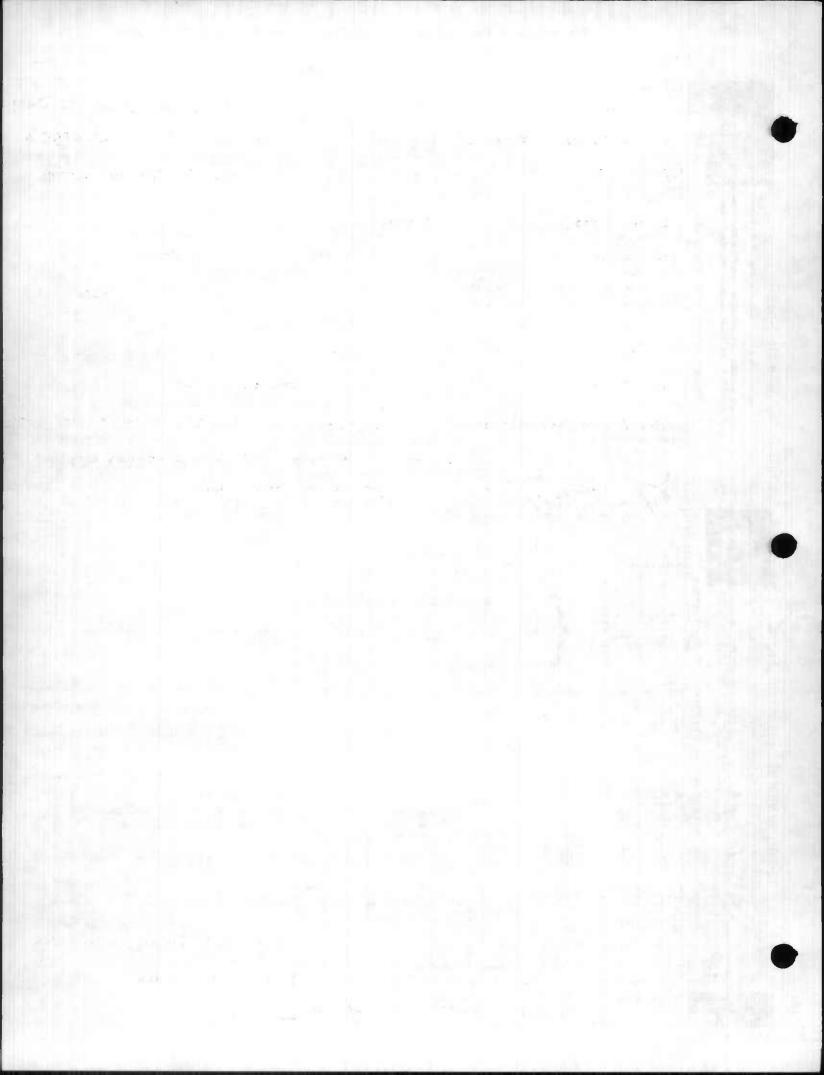
32. Registrer's Signature Zener

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3060 mitchelline RA # 103 Bome MD

20716

State



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 22, 2000 **Physician** 3:00 p.m Laura Edna Morgan /Medical 4b. City, Town, or Location of Death 4s Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 2002 Oakland Road Middle River Baltimore If Under 1 Months Year | If Under 24 Hrs. Days | Hours | Min. a Date of Birth (Month, Day, Ye Dec. 29, 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign , 1910 Maryland Funeral 10M 2QF 89 Ym. 220 07 0104 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or flerns 23a or 28e-f show 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Middle River 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 2002 Oakland Road 21220 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 20000 If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 Yes 210 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental F 7 is marked off Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ev-Elizabeth Schmidt John Moerschel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlyn G. Morgan (daughter) 2002 Oakland Road Middle River Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Pemoval from State Oak Lawn Cemetery 3/24/2000 Baltimore, MAryland 4 □ Donation 5 □ Other (Specify) 21-Bignature of Eugerel Serulae Esponsee Bruzdziński funeral Home PA 1407 Old Eastern AVenue Essex, Maryland 21221 is, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Physician /Medical mediate Cause (Final disease or condition resulting in death) Examiner Due to (or land) Examiner 5 H Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a conse physician Physician/Medical 8 Due to (or as a consequence of): = Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 signed by 1 □ Yes 2 No 3 Probably 4 Unknown à 24a. Was an autopsy 24b. Were autopsy findings available prior to Completed n of cause 1□Yes 2□No 89 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home SONesidence 6 □Other (Specify) 10 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 26c. Injury at Work? 28b. Time of Certification: Ather 1 SNatural 5 Pending investigation s after death. I Director: At 1 ☐ Yes 2 ☐ No 2 Accident 2th. Location (Street and Number or Plural Floute Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Funeral D etsly lilled

DHMH 16 Rev 6/95

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Attending

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certificate be

State Registrar

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29a. Certifier

(Check only

290. Signature and little of certifie

31. Date filed (Month, Day, Year) MAR 2 4 2000

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-Name and address of person who comp

Louis Semenoff MD

2108 Orems Road Middle River, Maryland 21220 32. Registrar's Signature

niner: On the basis of axa and manner traffed.

29c. License number

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LS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

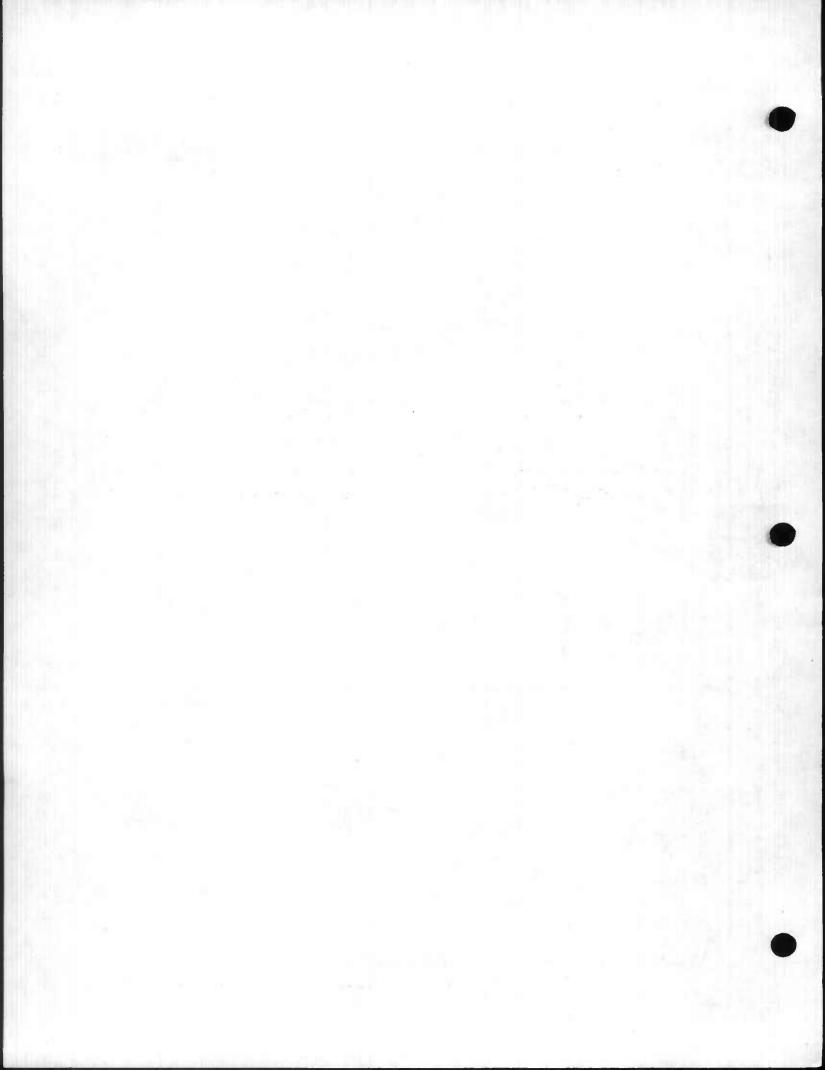
nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

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Placer

utur of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) Month 3 3. Tima of Death 2. Date of Death Margaretta Margiotta **Physician** 405P 5 60 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Pot.omac Montgomery 5. Social Security Number 152–18–7290 If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Aug. 16, 1904 If Under 1 Year Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M XXF 95 Yrs. Director Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Maryla must be notified at MD Potomac Maryland Montgomery XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 10714 Potomac Tennis Lane 20854 USA Funeral 14. Raca - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: p 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamentery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home LINK Department of Health and Mental Hy Important. If Health and Mental Hy Important. If Health are transferd other any Injury or other transferd other any Injury or other transferd. 17 Father's Neme (First Middle Last) 18 Mother's Name (First Middle Maiden Sumama) Be Max Dressler Stella Lawlor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 19e. Informent's Name/Ralationship (Type, Print) 4620 North Park Avenue Chevy Chase Maryland 20815 Corinne Kohn / Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☑ Removel from State Madonna Cemetery Fort Lee, 4 ☐ Donation 5 ☐ Other (Specify) march 25, 2000 Doda, Jr22 Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21. Signature of Funerel Service Licensee Victor P. 21230 23e. Pert1. Enter the disease, or complications that caused tendenth. Do not enter the mode of dying, such as cardiac or respiratory errest, abook, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical nech reumman Examiner Dua to (or as a consequence of) Examiner pue Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician of the burial Box 68760 that the death certificate be Physician/Medical Due to (or as a consequence of): 60 attending 980 ŏ Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. the signed by t 2000 3 Probably 4 Unknown 1 Yes à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deed 380 1 ☐ Yes 2 No certificate Division of Vital 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No this 28a. Data of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? Certification: After Attending 1 2 Netural 5 ☐ Pending death. 1 TYes 2 □ No 2 ☐ Accident investigation i or Attend after death Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 ☐ Homicida

To the Hospital or within 24 hours after To the Funeral Discompletely filled in

State Registrar

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29a. Certifier

(Check only one) 295. Signature and title of certi

31. Data filed (Month, Day, Year)
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Michael J. GRADY

30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 491() MASS AVE WW. WASH D (...

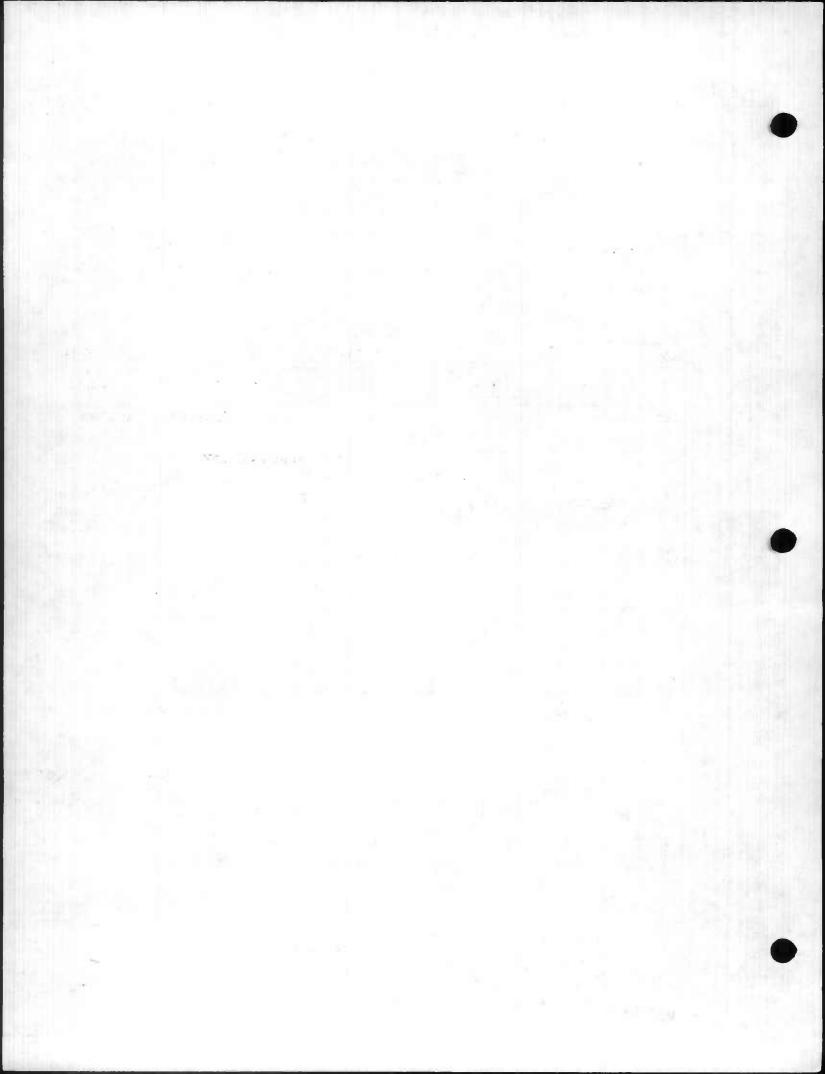
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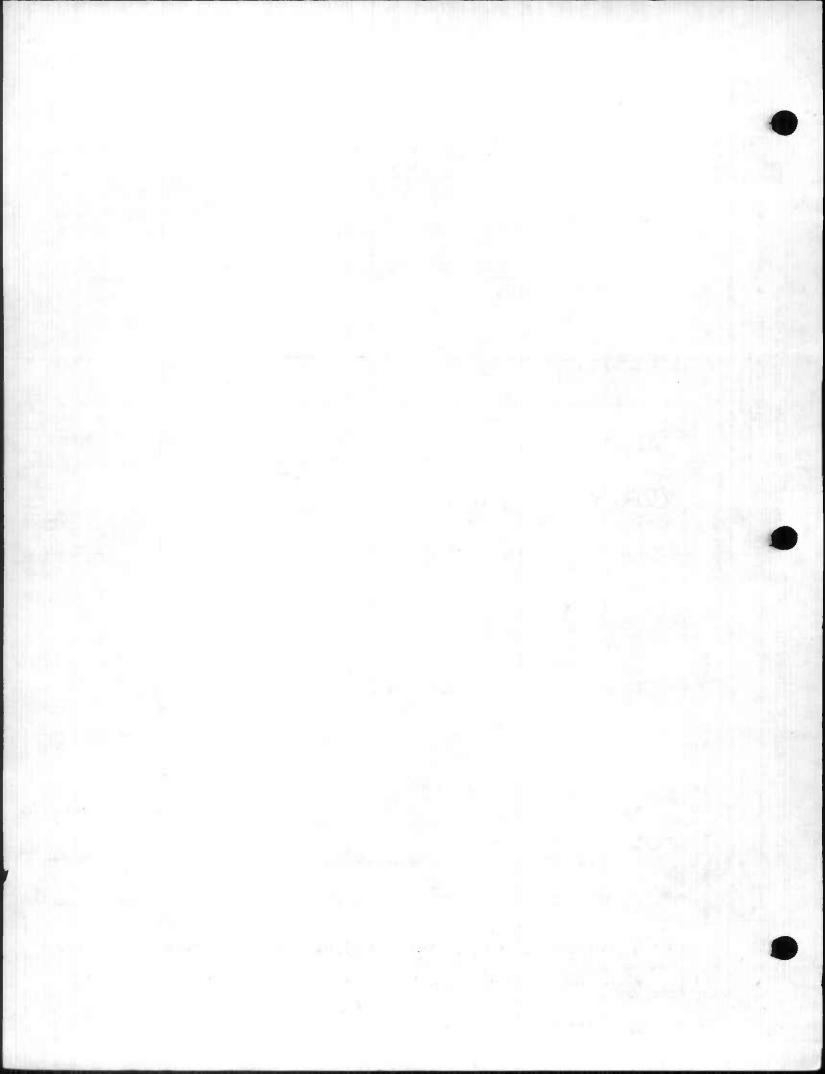
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled.

29d. Date signed (Month, Day, Year)



ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** JULIA MARTIN 72 2000 06.35 Am M March /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Medical Center) aton If Under 24 Hrs. 8. Dete of Birth Hours | Min. (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Deys 220-22-8426 September 14, 1926 73 Yrs. Director Usual Residence of Decedent the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits marked other than "naturel", or items 23s or 25s-f show imatic event, the Modical Expresser must be notified at 1 Yes 2 □ No Director HMORE Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10e 18 permit. Peges 1 end 2 should be filed within 72 hours after death 1 Depertment of Health and Mantel Hygiene. Important: If Item 27 Ie marked other than "naturelt, or Items 234 any Injury or other traumatic event, tre Feder Funeral 14. Race - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-tf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Merital Status orces? Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: If Yes, Give Year or Detes: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) ENVIRONMENTAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Lest Be 19e. Informante Neme/Relationship (Type, Print) daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALTIMORE, MO 21217 Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from Stete 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licenses GilMON Part1. Enter the disease, or complication that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical CHROMIC RENAL FAILURE 6 mo Examiner Examiner HYPERTEMSION physician end the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): attending phy Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEIZURE DISORDER þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was en autopsy performed? certificata has b 212 No 1 Yes 2 No 1 ☐ Yes Be 25. Was cese referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 (Natural 5 Pending 1 Yes 2 No investigation 2 Accident after deet! Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 24 hours after Funeral Directions blately filled in b 4 T Homicide 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and mention end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end manner stated. 29a, Certifier Medical (Check only one) within 2 To the

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Martin, Julia

State Registrar

29b. Signature and title of certifier

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

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31. Date filed (Month, Market 4 2000 32. Regular & Signeture

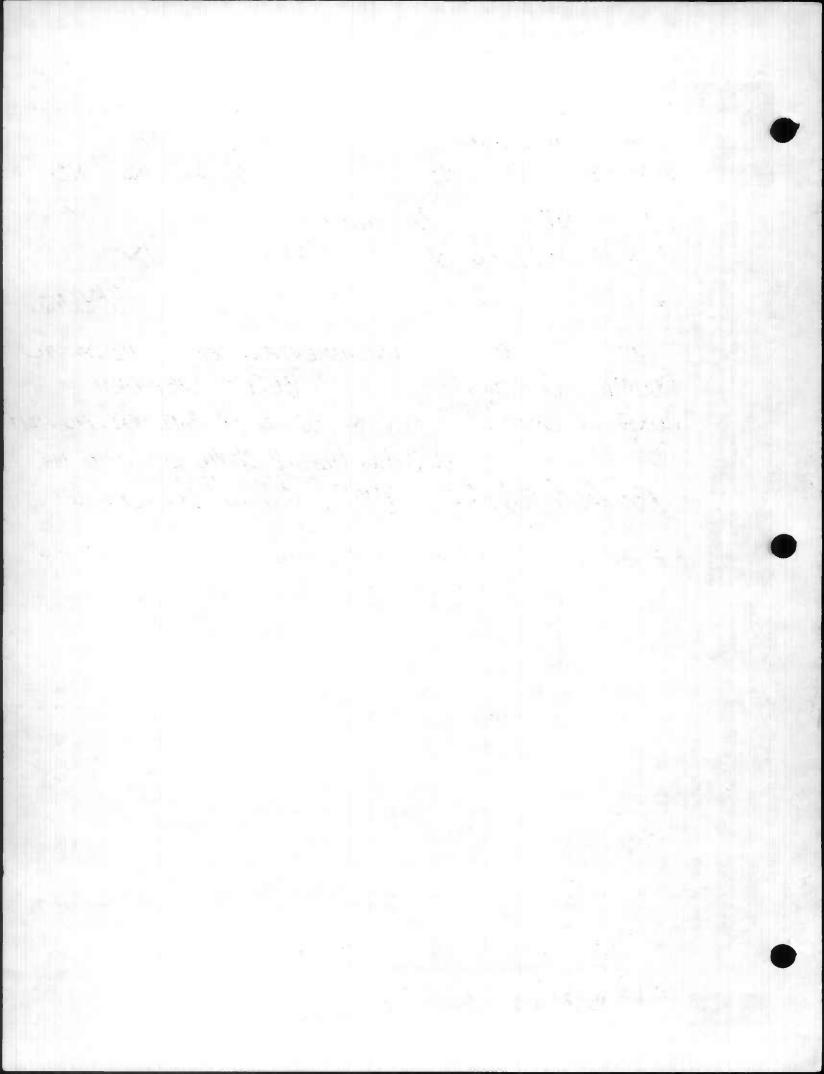
DHMH 16 Rev 6/95

29c. License number 29d. Dete signed (Month, Day, Year)

DRIVE BACTIMORE MD 21237

march 22, 2000

FRAMKLIN SOUARE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year ANNA B. MCLEWEE 6:05PM MARCH 16, 2000 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RIVERVIEW NURSING HOME BALTTMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 220-05-0922 1 M 20 F 84 Yrs. 20,1915 MARYLAND Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE CITY 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 GUSRYAN STREET 21224 U.S.A. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 200No 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: WHITE 3€ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 8 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) JOSEPH L. BETLEJESKI SOPHIA DELINSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD BETLEJESKI-BROTHER 314 GUSRYAN STREET BALTIMORE, MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/20/00 OAK LAWN CEMETERY BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224 Enjecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, othean failure. List only one cause on each line. Approximate Interval Between Onset and Death Varcular deseun Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yss 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) 20 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 ☐ Residence 6 ☐ Other (Specify)

attending physician use as the Por ed by the a P.0.

Examiner Physician/Medical Completed by page 2 funeral director, Be

27. Menner of Deet!

Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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Funeral

Director

rs 23s or 28s-f s must be notified

Pages 1 and 2 should be field within 72 hours after more of Health and Mental Hygiene.
sett if them 27 is marked other than "natural", or its settle of or other transmitten award, the Medical Examining try or other transmits event, the Medical Examining

Physician

/Medical Examiner

with the Maryland

21215-0020

altimore, Maryland

Hospital or Attending Physician: The law requires that the death certificate be assocuted s been signed by the should be detach has certificate edical Certification: To this After death. the within 24 hours after death To the Funeral Director: filled in by

Division of Vital Records,

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State Registrar

completely

29b. Signature and the of pertifier 30. Name and ddress of person who

5 Pending Investigation

6 Could not be

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28a. Date of Injury (Month, Dev Year)

29c. License number

Darks

28c. Injuny at Work?

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

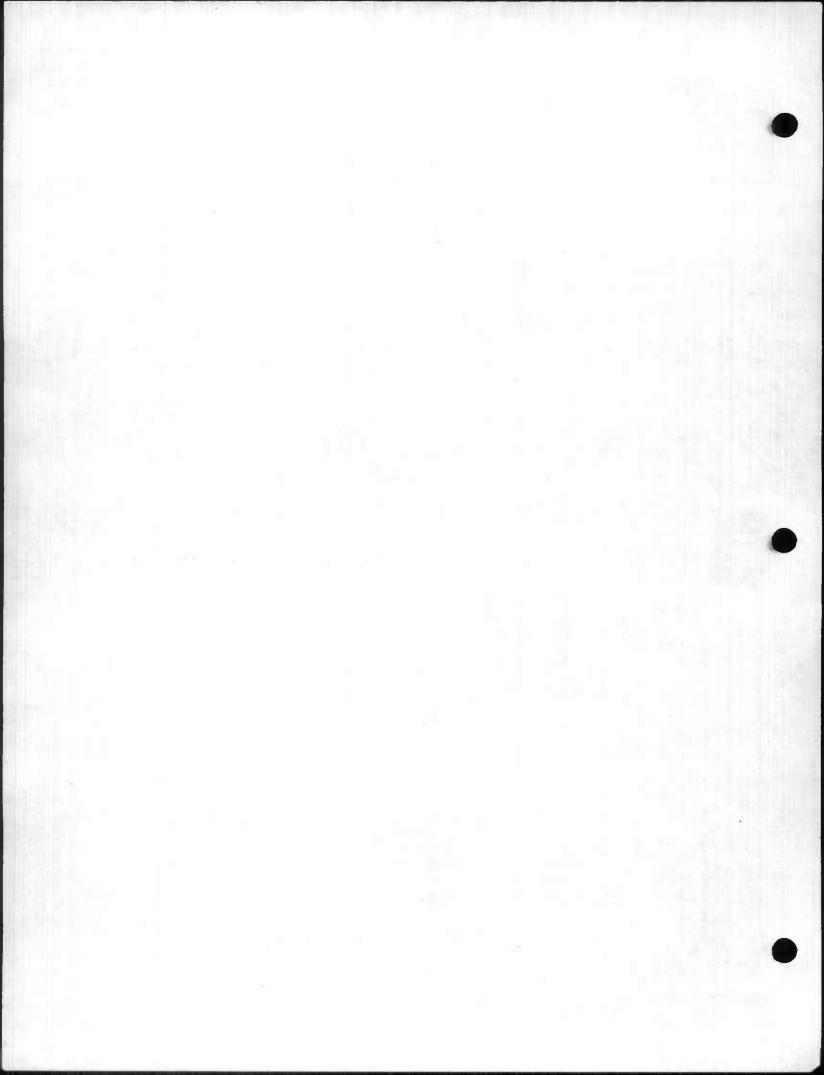
28d. Describe how Injury occurred

01

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) WAR 2 4 2000 Signature



Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #11 PER FH G781 3/24/2000 AH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lawrence E. Naylor 03 2000 8:40 A.M. 21 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Oakcrest Village Parkville Baltimore 6. Sex/ 15 M 2□ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Yrs 220-05-2263 80 Director 08/06/1919 MD. Usual Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Baltimore Catonsville Director ms 23a or 28a-f r cmust be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Barna 23a or 1012 Pleasant Valley Dr. 21228 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Nevel Married Za warmer 8 1 Yes 2 No Specify: Specify: 2 3 Widowed 4 □ Divorced Yeer or Detes: White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Brick Salesman Building Naylor, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be to and Mental P ortant: If Item 27 is marked Francis C. Naylor Sr. Mae Stallings 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 3 Calvins Spring Ct. Baltimore, MD. 21228 Wanda Deal Daughter 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State cometery, crematory or other place)
Loudon Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal trom State 03/25 Baltimore, MD. 4 □ Donation 5 NOther (SpecifyEntombment 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 21. Signeture of Funeral Service Licenses when 736 Edmondson Ave. Baltimore, MD. 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finat ENDSTAGE CHRONIC LUNG DISEASE disease or condition resulting in death) Examiner Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician s the burial Box 68760 90 Physician/Medical Due to (or es a consequence of) 88 23b. Dtd tobacco use contribute to the cause of death? Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1 Yes 2 No 3 Probably Unknown should be detach þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA this 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 1 Auleturel 2 Accident Attending 5 Pending ne Hospital or Attending n 24 hours after death. 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 115 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certitier 29c. License number 29d. Date signed (Month, Day, Year) 2564 and address of person who completed cause of death (trem 23a) (Type, Print) Blud/Bultman MD

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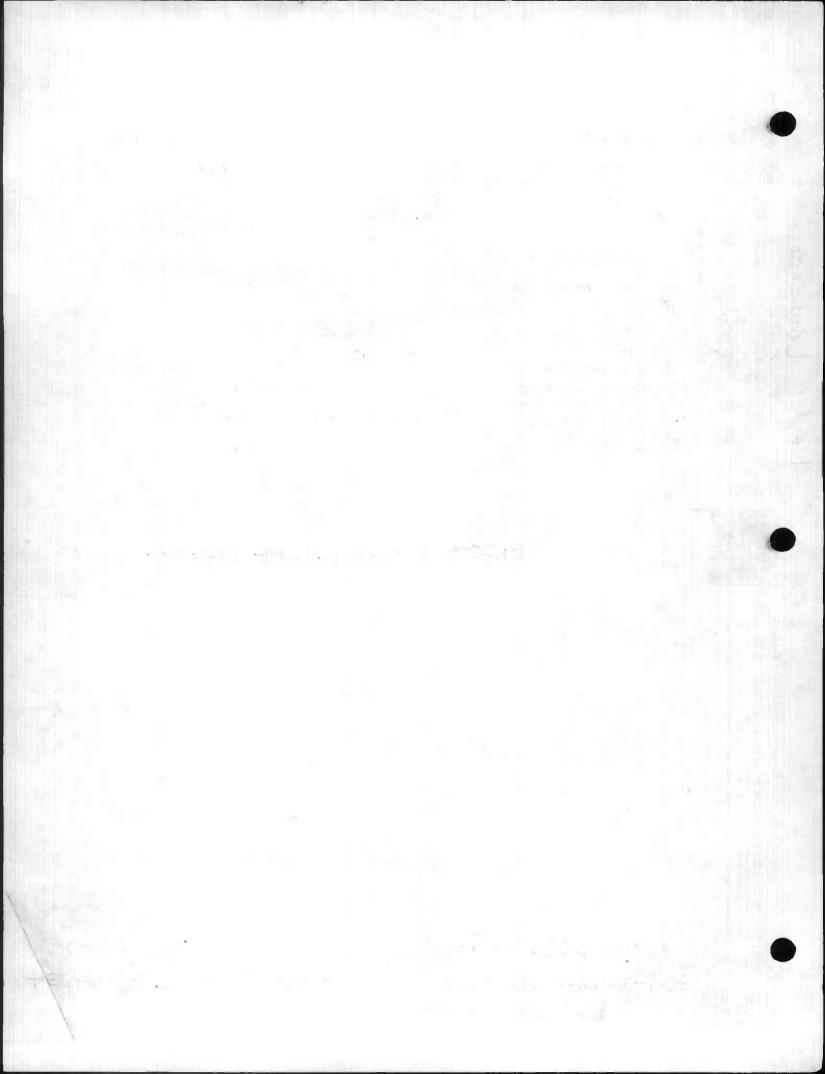
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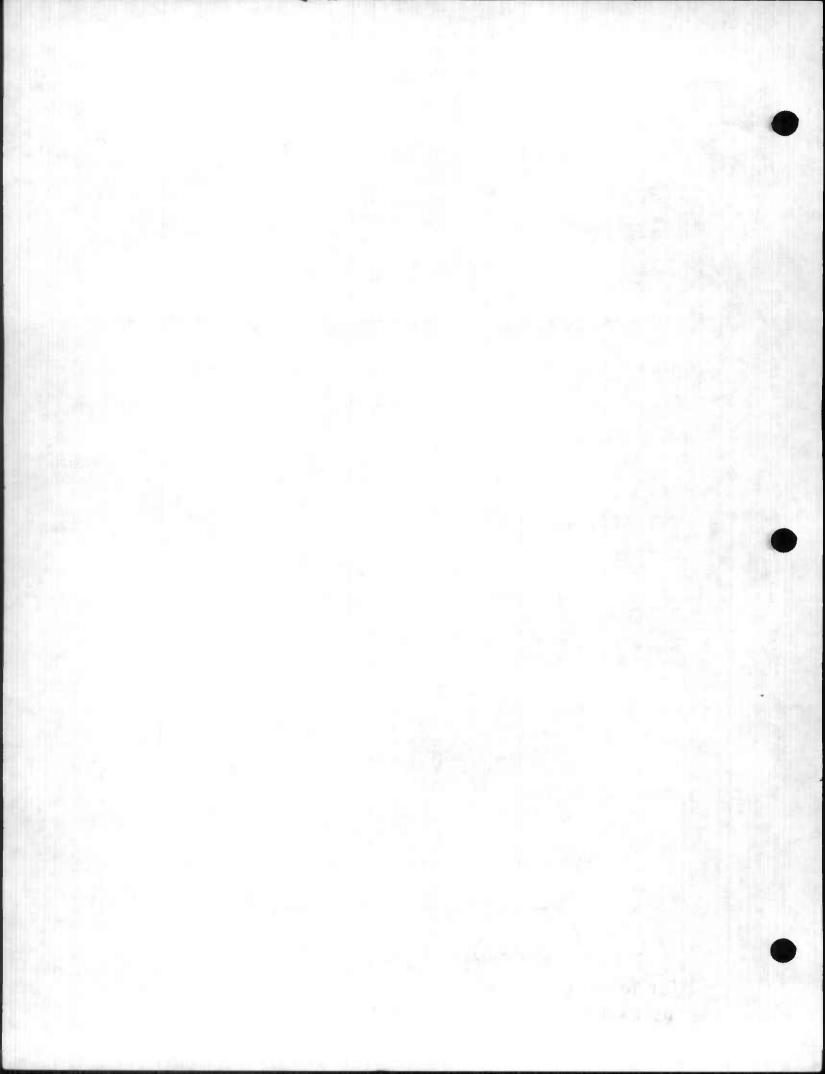
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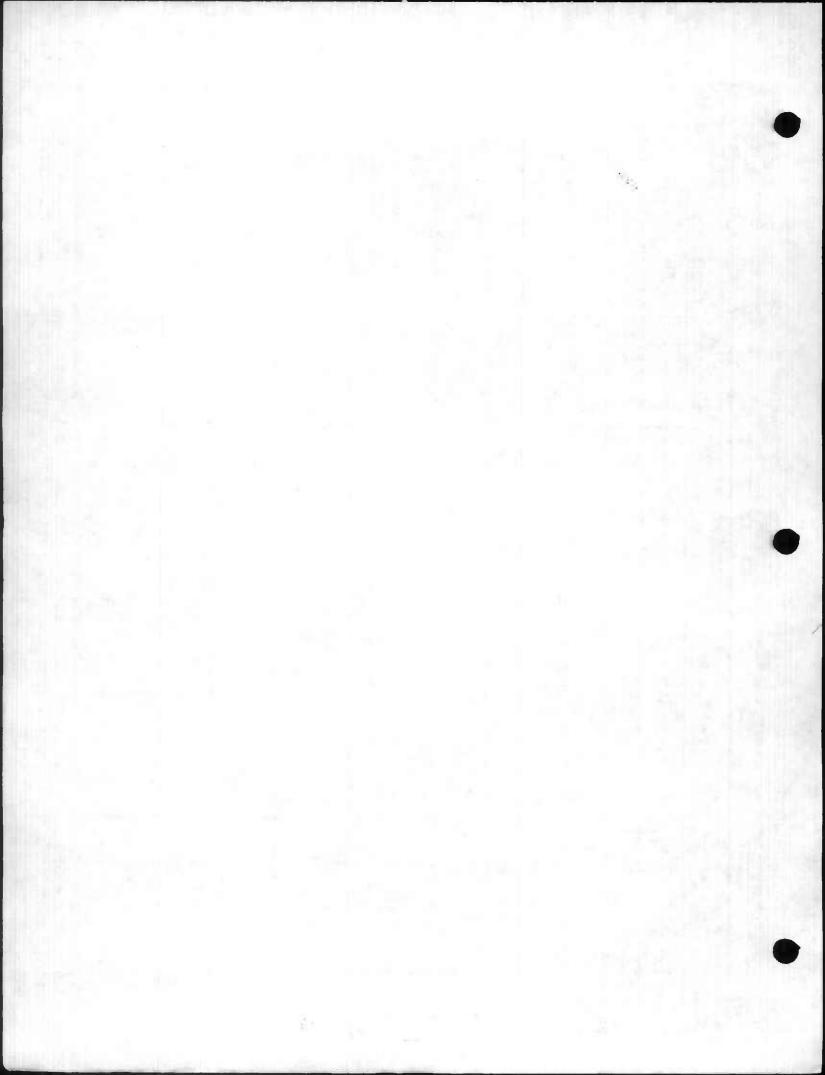
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State of Maryland / Department of Health and Mental Hygiene

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	Darlene P. O'Re	i11v					Month	Day	Year		
dical	4a Facility Name (If not institution, give sti				4b. City. T	own, or Lo	March cation of Death			4:44 A.	
iner	North Arundel Hosp					Burn		Anne		del	
ı	5. Social Security Number 6. Sex		(In yrs. last birthdey)	If Under 1 Y	ear If Unde	r 24 Hrs.	8. Date of Bird	h		place (Stata or Fo	
	219-70-6645	M 21X F	35 Yrs.	Months Da	Days Hours Min.		(Month, De	7 1964 Mary		aryland	
	Usual Residence of Decedent										
	10a. State 10b. County 10c. City, Town or Location								1	10d. Inside City Li 1 ☐ Yes 2 ☒	
Funeral Director	Maryland Anne Arur	nde l	Glen	Burnie							
2	10e. Street and Number			10f. Zip Cod	21060			10g. Citizen of \	What Cour USA	itry?	
10	7647 Spencer Road	. W B d 4				1-1-0 (000	-4			can Indian,	
	11. Merital Stetus 12 Never Married 2 Married	 Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N 		Was Decedent If Yes, specify (Cuben, Mexica	in, Puerto F	Rican, etc.)	Blog	ok White	etc	
	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐	No Specify	<i>:</i> :		Specify	Whit	,e	
3	15. Decedent's Educa	itlon	16a. Dece	dent's Usual Or	cupation			16b. Kind of B	usinass/In	dustry	
Be Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) Collega (1-4or 5	4.1	kind of work do DO NOT use re		st of workir	ng			1341	
5	Unknown	College (1-40) 5	Woo	dwork-P	ottery			Provid	ence	Center	
	17. Father's Name (First, Middle, Last)							Maiden Sumen	10)		
permit Fages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: if item 27 is marked other than "natural", or items 23s or 25s-1 show any injury or other traumatic event, the Medical Emerican must be notified at once. To Be Completed by Funeral Director	Thomas P. O'Rielly Barbara							Smith			
	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mail	ing Address (St	reet and Numb	ber or Rura	A 102 - C	er, City or Town,	State, Zip	, MD. 211	
	Patra Avee										
	20a. Method of Disposition 1 Burial 2 Cremation 3 Re	movel from State		metory or other	plece)	M	arch27	20c. Location -	City or To	own, Stete	
	4 ☐ Donation 5 ☐ Other (Specify)		Holy Cro	oss Ceme	etry		2000			Maryland	
any Inj page	21. Signeture of Poneral Service Licenses		llings Funera Home, P.A.								
	23a. Part 1 Enter the declaration or complications the ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one clause of each line. Approximating the declaration of the death of the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, and the death of the death.										
/Medical Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	E. I.	Due to (or as a conse								
ysiciai	Part II. Other significant conditions contr		iven in Part I. 23b. Dfd tobacco use contribute to the cause of deat								
5				underlying caus	e given in Parl	1.					
7	DOWN'S SYNDROME			underlying ceus	e given in Parl	1.		tobacco uss co Yes 2 No		to the cause of debably 4 Unit	
pleted by P				underlying ceus	e given in Parl	1.	1 🗆		3 Pro		
ompleted by P				underlying ceus	e given in Part	1.	1 D	Yes 2□ No en eutopsy ormed?	3 Pro	Vere autopsy findivaileble prior to ompletion of ceus death?	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** March 20, Mary Edna Poole 2000 1:35 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 927 Washington Blvd. Baltimore n/a 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace /State or Foreign **Funeral** 1□M 2QF Country) MARYLAND 61 Director 219-26-4683 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 X Yes 2 □ No Director N/A Nems 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 927 WASHINGTON BLVD. 21230 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 ☒ No 'natural', or 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ♥ Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Mental is marked RAYMOND EDWARD LIPPY **EDNA** CECILIA CHALK To 19a, Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health WANDA L. KROENING DAUGHTER 508 EASTERN COURT ABERDEEN. MD Department of Health Important: If Item 27 20b. Plece of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete cemetery, cremetory or other plece) CEDAR HILL CEMETERY 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removel from Stete 3-23-2000BROOKLYN, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, of complications that caused the dishock, or heart failure. List only one ceuse on each line. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Death Physician /Medical Immediete Cause (Fine disease or condition resulting in daeth) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): De exect physician s the burial Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably Unknown 2 24b. Were autopsy findings aveilable prior to completion of cause of death? ate has been si page 2 should i Completed 24a. Wes an autopsy 1 Yes No certificate director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA MIS 27. Menner of Deat 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Allar 1 Neturel 2 Accident Attending 5 Pending investigation if or Attanding after death. 1 Yes 2 No 3 Sulcide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) B 4 Homicide Funeral E Certifier Continuing Pyrelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. adical ner: On the hasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 1ARCH 22, 2000

State Registrar

DHMH 16 Rev 6/95

Saltimore, Maryland 21215-0020

Box 68760

P.O.

Records.

Division of Vital

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31. Dete filed (Month, Day, Year)

Registrer's Signature

with (Item 23a) (Type, Pynt)

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ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year William Porter March 20,2000 3:50 AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Middle River If Under 24 Hrs. | 8. Data Ivy Hall Geriatric Center Baltimore Birthplace (State or Foreign Country) If Linder 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 8. Data of Birth (Month, Day, Year) Hours Months Days 10 M 20 F Yrs. 216 07 6401 Dec. 7,1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2□No Maryland Baltimore Middle River t0g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2213 Old Eastern avenue 21220 USA 12. Was Decedent Ever in U.S. Apped Forces? 1 Pyes 2 □ No If Yes, Give Year or Dates: 1,71,7 TT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black White etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced WW II White X 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Aero-Space 12 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) William Porter Edith Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isabelle Sprinkle (niece) 1305 Fordham Court Bel Air Maryland 2104 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Orems Meth. Church Cem. 3/23/00 Baltimore County, Md. re of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old EAstern Avenue Essex, Maryland 21221 cations that cautain the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e, or compli List only or Approximata Interval Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic endstage obstructive pulmonary disease 2 years Due to (or as a consequence of): Arteriosclerotic Cardiovascular disease Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): End stage dementia Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autoosy

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if flem 27 is marked other any Injury or other treumatic event pages.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

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e filed within 72 hours effer deeth with the Meryle other than "netural", or fleams 23s or 28s-f ehov vent, the Medical Examine must be notified at

with the Menyland

altimore, Maryland 21215-0020

Examiner 8

25. Was case referred to medical 27. Mapner of Death

Physician/Medical à Completed B 2

physicien and s the burief-transit ate has been signed by the pege 2 should be detech certificate director, this Certification: Affec deeth. e Hospital or Attendi n 24 hours effer desth. e Funerel Director: A pletely filled in by the f

The lew requires that the death certificate be executed 68760. Box (P.O. Records. Vital Attending Physician: to Division

> within 24 hou To the Fune completely fil edical \$ State

Registrar

31. Date filed (Month, Day, Year) DHMH 16 Rev 6/95

1 Yes 2 No

1 Natural

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

29a. Cartifier

M.D.

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Tima of

D31464

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d, Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 N. HASITMI SHOA113

MAR 2 4 2000

5 Pending investigation

6 Could not be

outs

ORIGINAL

26. Place of Death (Check only one)

24b. Ware autopsy findings available prior to completion of cause of death?

1 Yes 2 XNo

1 Tyas 2 No

Other: 4 Nursing Homa 5 Residence 6 Othar (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

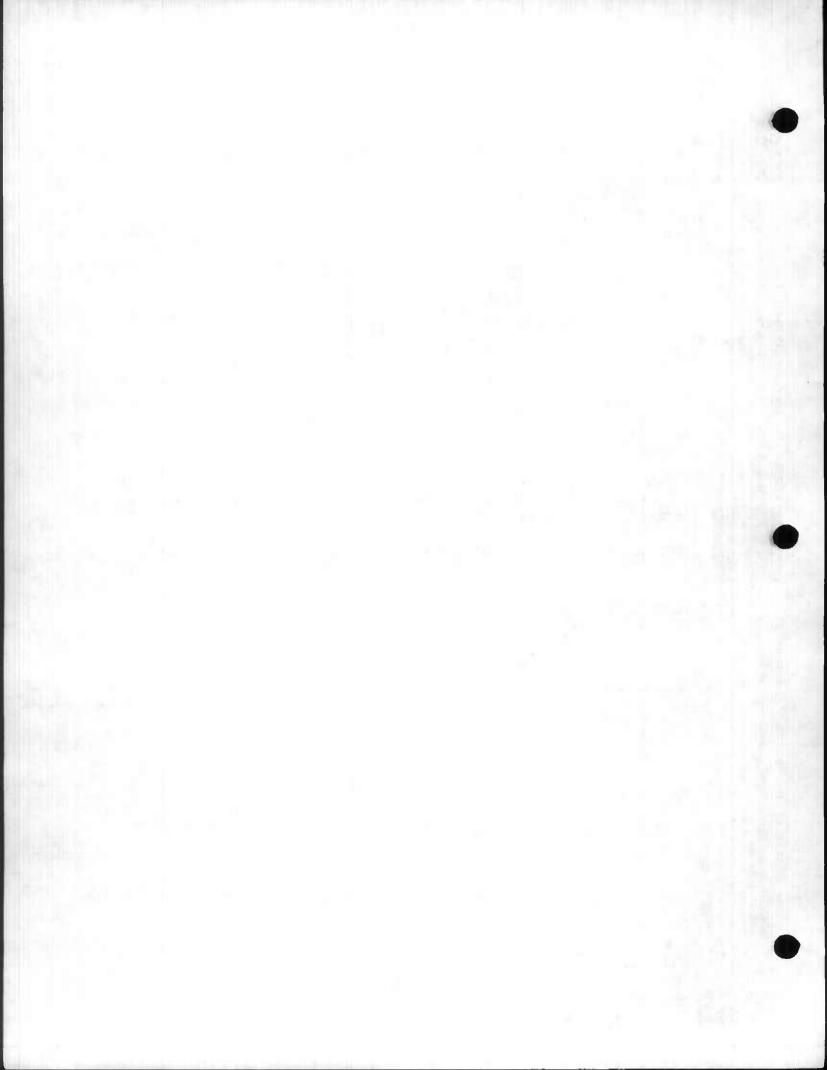
*** Like The State of the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Entaw St Sente 308 Balt. MD 21201

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

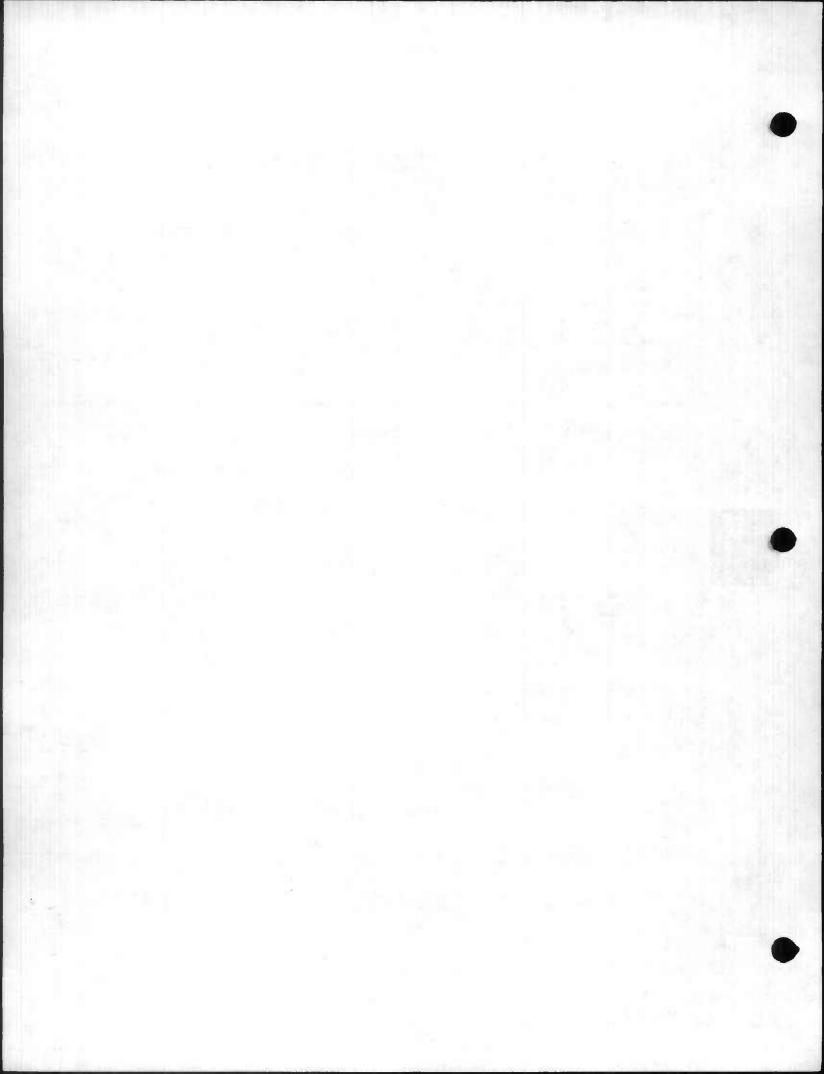


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State of Maryland / Department of Health and Mental Hygiene 10 00500

		Decedent's Name (First, Middle	(ast)		Certifi	cate of	Death	2. Date of De	Reg. No.		3. Time of Death
Physicia	_						Month	Day	Year 2000	9:29PM	
/Medic Examin		George Willi 4a Facility Name (If not institution		4b. City, Town,	March or Location of Deat			9:29PM			
Examin	CI	319 South Co					Ralt	imore		N/A	
Funeral		5. Social Security Number	6. Sex	7. Age (in yrs. ia		Under 1 Year	If Under 24 H	rs. 8. Dale of Bi	th Year)	-	lace (State or Foreign
Director		217-24-2525	1⊠M 2□F	70	Yrs.	unio Cuyo	TIOGIS IV	May 11	, 1929	Mar	y1and
pu *		Usual Residence of Decedent 10a. Stete 10b. County		10c. City.	Town or Locatio	0				1	0d. Inside City Limits
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Baltimore, Maryle permit. Pages 1 and 2 should Department of Health and Merimportant: if them 27 is marke any injury or other treumstic page.		20a. Method of Disposition		20b. Ple	ace of Disposition	(Name of		Date	20c. Location	- City or To	own, State
Page Page ment in it. It		1 ☑ Buriel 2 ☐ Cremetion 4 ☐ Other (S		State				k3/24/00	Elkri	dge.	Maryland
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apita nours nerel		29a. Certifier Certifyln	Physician: To the	best of my knowl	fedge, deeth occi	urred at the ti	me, date and pla	ice, and due to the	cause(s) and m	anner as s	tated.
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral	edical	(Check only 2 Medical	xaminer: On the ba and menn	sis of examinetic	on and/or investig	pation, in my	opinion, death or	curred at the time,	date and place,	and due to	the cause(s)
To th To th comp		29b. Signature and title of certifier	, ,	11-	1	29c. Licen	se number	1	29d. Date signe	ed (Month,	Day, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#2 PER MD. G781 3-24-2000 JAB Reg. No. 2. Data of Death3-12-2000 Month Day Year 1. Decedent's Name (First, Middle, Last) **Physician** JAMES RUBERTS MARCH 8000 /Medical 4e Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BONTIMORE of morni my UNIVERSITY If Under 24 Hrs. If Under 1 Year B. Dethi of Birth (Month, Day, Year) Soptist 11, 1934 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-30-8370 Usual Rasidence of Dacedent 1XM 20 F **Director** maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Copartment of Haalth and Mentel Hygiene.

Lingortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic avent, the Mazes Examples must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yas 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Chauncex Ave U.S. 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 Yes 2 No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No. If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Merital Status 1 Never Married 2 Married 1 ☐ Yas 2 No 21215-0020 Specify: Specify: ack þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Irueking Truck Driver 12-th Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 8 Charles Kober Ander son martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkside James M. Roberts JR-- Saw 4202 Drive Bacto. Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data Burial 2 Cramation 3 Removal from State 3/16/00 Mount 2100 cemetery Lansdowne 21. Signature of Funeral Service License / Lewis T. Guynn 22. Nama and Address of Facility Lewis T. Guynn Fineral Home 4517 Parkheights Ave. Balto. md. 21215-6393 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one certain and line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final CARDIAC DRR THMIA

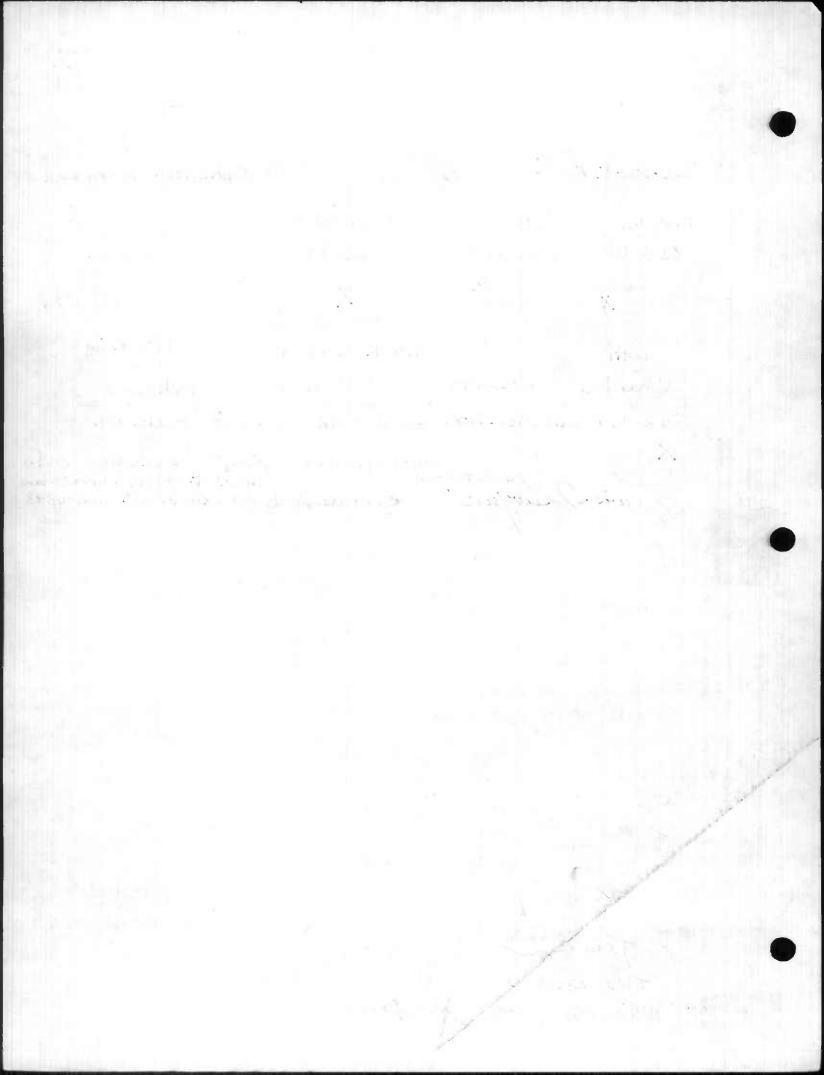
Dua to (or as a consequence of): diseesa or condition rasulting in death) Examiner MYOCARDIAL INFARCTION

Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disease or Injury that initiated events rasulting in death) Last and DRONDRY ARTERY DISITASE

Dua to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical tha Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 1 Tinknown 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autoosy 1 Yes 2 No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was casa refarred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 27. Menner of Death 28b. Tima of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No invastigetion 2 Accidant 6 Could not be datarmined 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Cartifian (Check only one) 29b. Signeture and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 2/12/00 P13400 Lui 1 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) MINIVERSITY OF MARGLAMD 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State MAR 2 4 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** Month Year Ruby Karen SILE 6:40 AM 2000 Jacob /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Roseda If Under 24 Hrs. Franklin Square Hospital
5. Social Security Number 6. Sex 7. A Center Baltimore If Under 1 Year Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 200 216-54-3413 49 Yes 2,1951 Director Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yas 25 No 239-7 Dundalk Baltimore Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2615 Plainfield Road 21222 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11 Maritat Status Black, Whita, atc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Cashier Retail 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 Pages 1 and 2 should be sent of Health and Mental Frances E. Snyder Robert D. Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. Robert D. Ruby (Father) 2615 Plainfield Road Dundalk, Maryland 21222 mportant: If Item 27 ny injury or other to Baltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State Hilltop Service Corp. 3/24/2000 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland ane of periplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final Busilar disease or condition resulting in death) Examiner Examiner Basilar Tip Angurysm physicien and the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to Records, þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 carlificata 1 Yes 2 No 1 Yas 2 No Division of Vital or Attending Physician: funeral director. Be 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yas 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 MNatural within 24 hours after deeth. To the Funeral Director: A 1 Yas 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. Medical completely (Check only one) the sta 29b. Signature and titla of certifie 29c. License number 29d. Data signed (Month, Dav. Year) 22,2000 who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Bultimore, Maryland 21237 9000 Month, Day, Year) registrar's Signature State MAR 2 4 2000 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#20B&C PER F.H. G781 3-29-2000 JAB Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day ZZ NO. DDIE RICHARDSON MARCH 2000 0351 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HUSPITAL 16. Sex BALTIMORE BAltimurE OF DINAI If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 242-34-4513 10 M 20 F Months 3 Yrs. MARCH 6. 1927 NORTH CAROLINA **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SUFFOLK 21215 AVENUE USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER BETH STEEL 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN ANNIF RICHARDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUFFOLK AVENUE, BALTIMORE, MO, 21215 ition (Name of Date 20c. Location - City or Town, Stata BALTIMORE MARYLAND) 2812 KIM MILES 20b. Place of Disposition (Name of conneter), crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/27/00 RANDALL STOWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility WYLLE FUNERAL HOME PA 21. Signature of Funeral Service Licenses 638 N. GILMOR STREET. BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart lailure. List only one cadse on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Plmonary Duesse . End STAGE CHronic OBSTRUCTIVE

Physician /Medical Examine

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certificate hes

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To the Hospital or Attendin within 24 hours efter deeth. To the Funerel Director: Aft

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Certification: To

Medical

The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

or Attending Physician:

Physician

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Examiner

10a. State

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than "natural", or lier the Medical Examiner filed within 72 hours after

Hygiene.

Pages 1 and 2 should be nent of Health and Mental

or other th

Baltimore, Maryland 21215-0020

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CICHARDSON

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical

	out to for as a consequence or.	
b	Due to (ease of the control of the c	
	Due to (or as a consequence of):	
С	Due to (or as a consequence of):	
0		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Loss Long Concer

23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown

Cancer

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 20 No

25. Was case referred to medical examiner? Hospitat: 15 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 21XNo 27. Manner of Death

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 No

28a. Date of Injury (Month, Day Year) 1 Ø Natural 2 ☐ Accident 5 Pending investigation 6 Could not be 3 Suicide

28c. Injury at Work? 28d. Describe how injury occurred

28b. Time of Injury 1 Yes 2 No Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier reister

RES COO

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (ttern 23a) (Type, Print)

Meister SIMAI Hnonew Altimule

31. Date filed (Month, Day, Year)

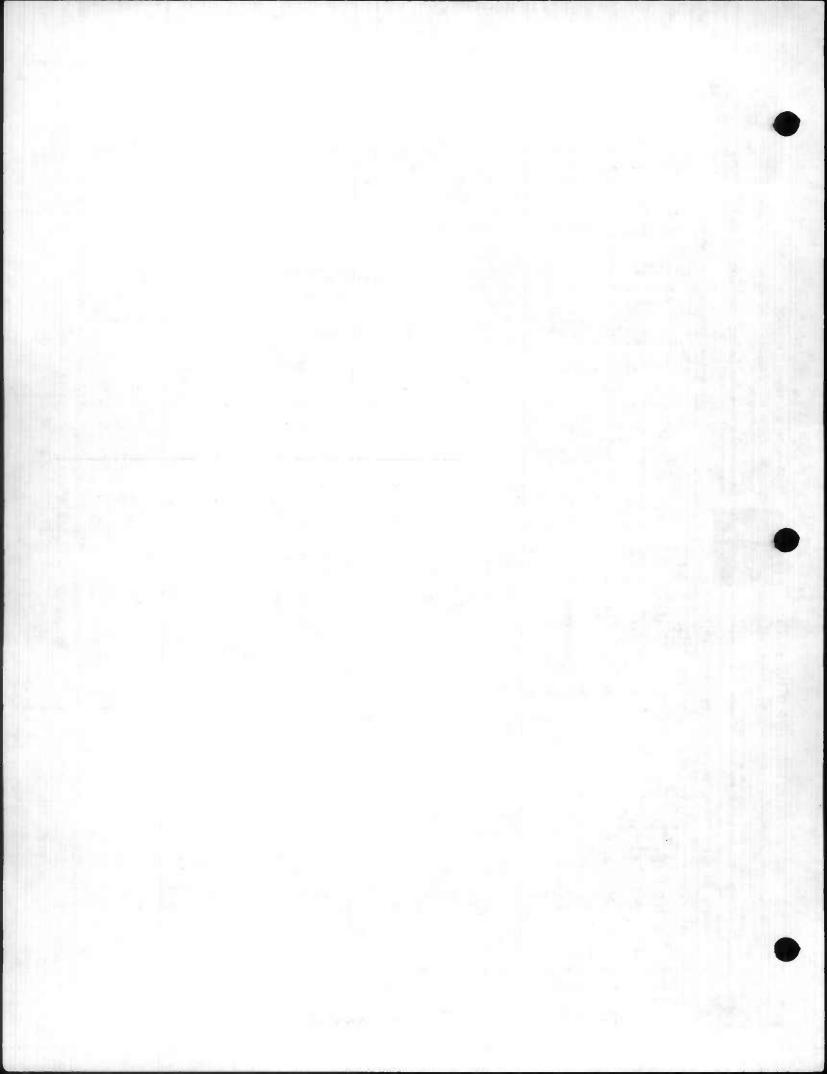
4 ☐ Homicide

2000

32. Registrar's Signature Dener

Registrar

completely



Physician /Medical

Examiner

Funeral

Director

"natural", or Name 23s or 28s-f

Department of Health and Mental Hygiena Important: if Item 27 is marked other than any injury or other traumstic event, the Me

Be Completed by Funeral Director

	Diagon	Tuna or Drie	A In Blac	le lac	delib!	in lak	Acci	Α.	II Canlae	fro Logi	lbla.			
	Please	State of Ma		Depa	artmen	nt of H		and M	Mental Hyg) ()	9527		
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ASSESSMENT OF THE PARTY OF THE		Thomas H	H. Robi	nsor	1				Month	Day	Year 2000	4:55 A.M.		
4a Facility Name (If no	not institution, giv					7	4b. City, To	own, or L	ocation of Death			11.00 11.11	-	
Gilchri	st Cente	er		Towson						Ba1	1timo			
5. Social Security Num 248 30 46	622	Sex 7. Age	e (In yrs. last bii 76	Yrs.	If Under Months	er 1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day, July 14	, Year)		intholace (State or Foreign Country) Virginia		
Usual Residence of De			The Tra										7	
Maryland	10b. County Baltim	nore	10c. City, Tow Essex		ation						1	10d. Inside City Limits 1 ☐ Yes 2X No		
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324 S. Wo	oodward	Drive				2122	1			U.S	3.			
11. Marital Status		12. Wes Decedent E Armed Forces?		13. W	Vas Dece	ident of H	lispanic Or	igin? (Sp	pecify Yes or No- o Rican, etc.)		ce - Americ			
1 Never Married 3 □ Widowed 4 €		1 Yes 2 No If Yes, Give			Yes, spec				HICAN, etc.)	Specify	60	k, White, etc. White		
15	5. Decedent's Ed only highest gra	ducation		(Give k	kind of wo	ual Occupi	during most	st of wort	king	16b. Kind of Bu				
Elementery/Seconde 8th	ery (0-12)	College (1-4or 54	+)	Maintenance General Motors										
17. Father's Neme (Fir		() George Wash	nington	Rob	inso	on	18. Mothe		ne (First, Middle, Maudie D.		ne)			
19e. Informent's Neme							and Numb	er or Rui	ral Route Number	r, City or Town	, State, Zir	p Code)		
		/ Former w		A A SULL	-		ard Dr		_	x, Mary		01001		
20e. Method of Dispos	sition Cremetion 3 🗆	Removel from State	20b. Place o cemete.	of Disposi ery, cremi	sition (Nam	ame of other plac	ice)		Date	20c. Location -	- City or To			
21. Signature of Funer	erel Service Licen	**	rushi	400	Name an	and Addres	ess of Facilit	lity Lghwa	Gonce Fu	uneral imore,	Home	P.A. 21225		
shock, or heart for Immediate Cause (Fin disease or condition resulting in death)			ne. astatic		,					06461	(4)	Interval Between Onset and Death	the	
(95Ultrig in Gean)		r	Due to (or es a		vence of):	1	110 1							
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that initieted events resulting in death) Las		d	Due to (or as a	consequ	ence of):									
Pert II. Other significa	ant conditions c	contributing to death but	ut not resulting	in the un	nderlying	cause gir	ven in Pert	I.	23b. Did t	obacco use cr	ontribute t	to the cause of death?	7	
	•									res 3/2 No		obably 4 Unknow		
									24a. Was a perform		80	Vere autopsy findings vailable prior to ompletion of cause f death?		

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

nor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-tran

Be Completed by Physician/Medical Examiner

Sequentially list if any, leading to cause. Enter Un Cause (Disease that initieted everesulting in death Pert II. Other sig

29a. Cartifier (Check only one)

After this certificate has

To the Hospital or Attandir within 24 hours after death. To the Funeral Director: A

State Registrar

25. Wes casa referred to medical examiner? Medical Certification: To

1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 ☐ Homicide

6 Could not be determined

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year)

28b. Tima of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes

Other: 4 | Nursing Home 5 | Residence 6 DOther (Specify) HOSPICE

28d. Describe how injury occurred

21204

29c. License number

1EC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

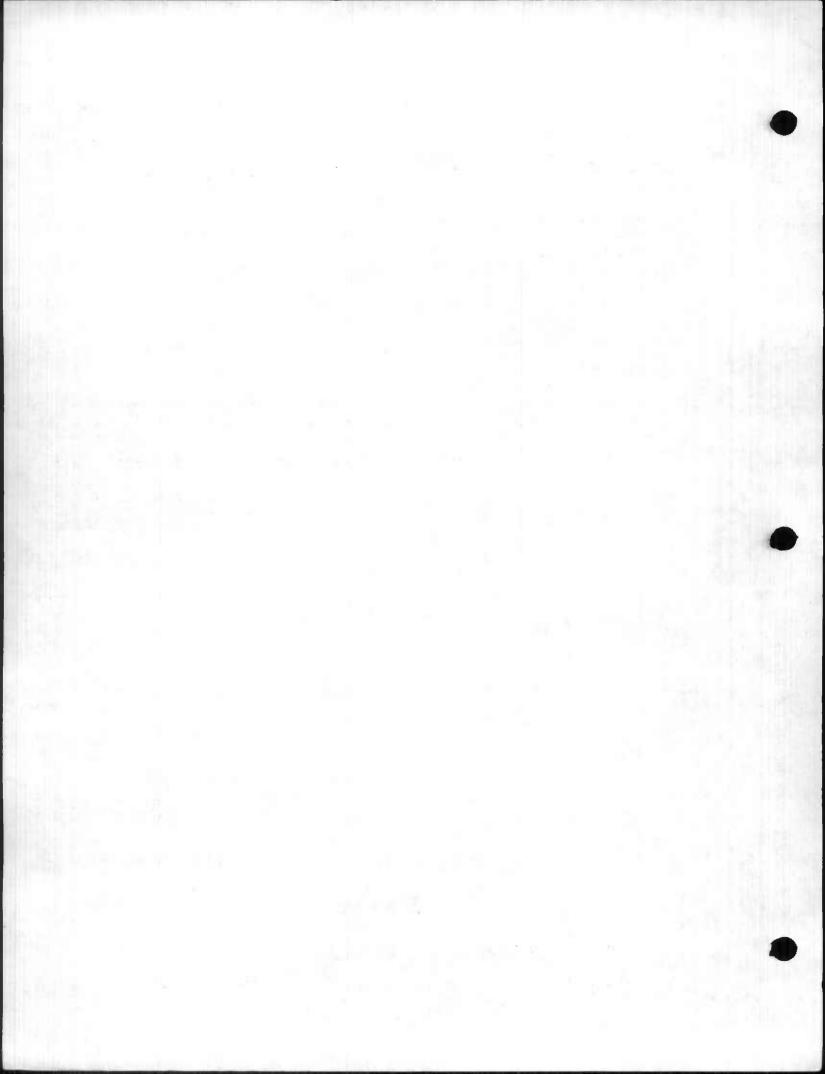
29d. Date signed (Month, Day, Year) MArch 21, 2000

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A.Riley GBMC 6701 N. Charles

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 24

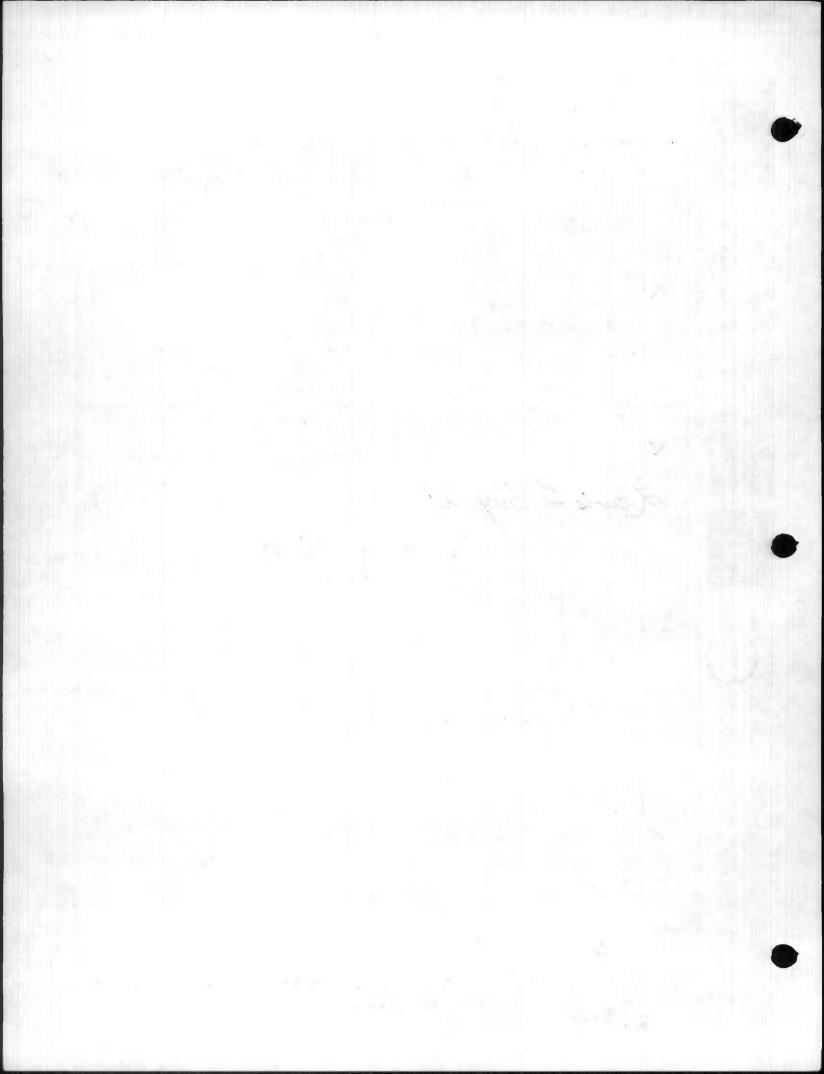
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Registrar

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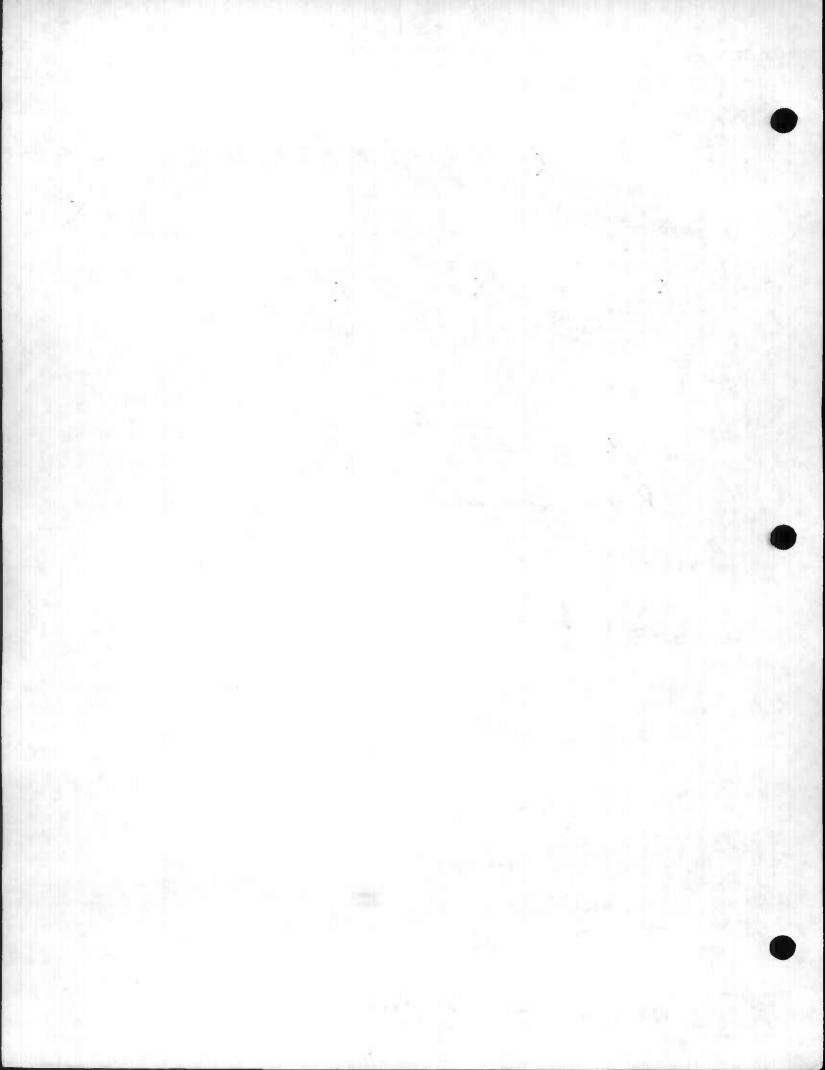


crn Shannon Smith

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State of Maryland / Department of Health and Mental Hygiene

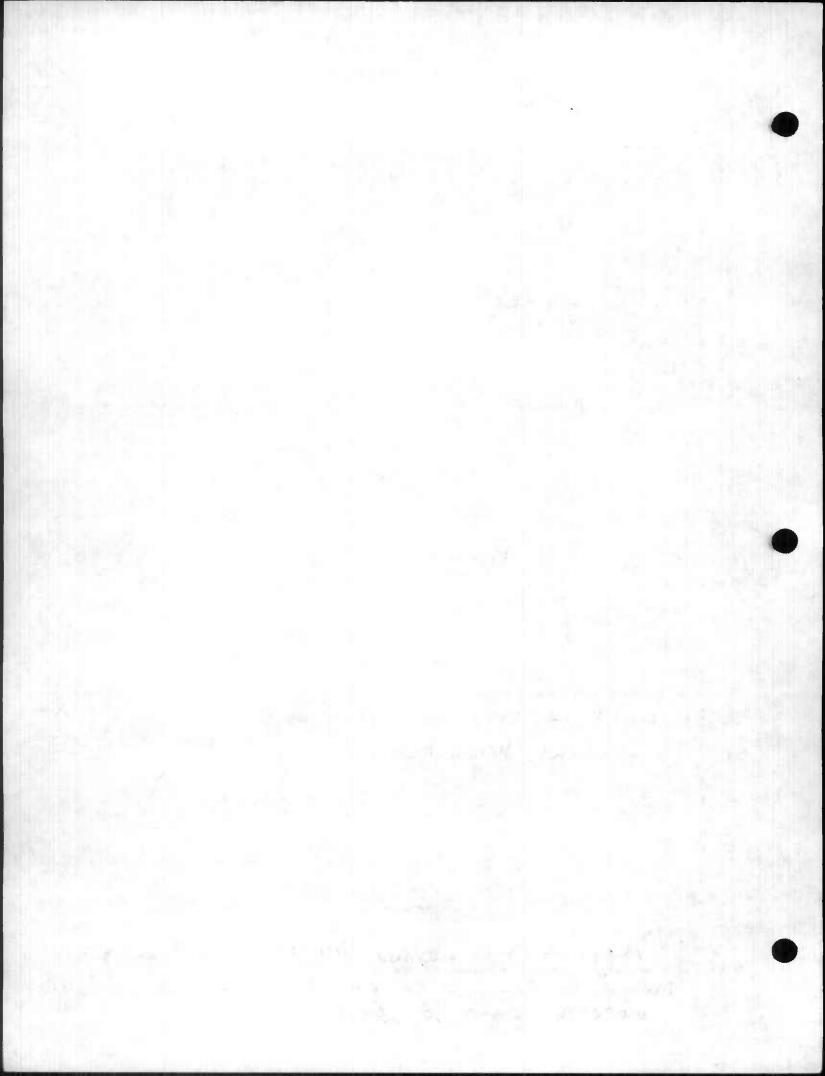
1 SHILLI			C	ertificate of	Death		Reg. No.	09529		
Dhuchian	1. Decedent's Name (First, Middle, La					2. Data of De Month	eth Day	3. Time of Death		
Physician /Medical	SHANNON	E. SM	ITH			March	22, 2000			
Examiner	4a Facility Name (If not Institution, giv					Location of Deatl				
	Good Samaritan Ho	-	- do not be hade also	(v) If Under 1 Year	Baltimo:	8. Date of Bir		1/A		
Funeral Director	5. Social Security Number 6. S 217-94-5103	Man	Yrs.	Months Days	Hours Min	MARCH	8,1980	9. Birthplace (Steta or Fore MARYLAND		
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene 1740/2009. Wher then 'natural', or terms 23s or 28s-1 show ent, the Madreil Examiner must be notified at a Completed by Funeral Director	10a. Stata 10b. County	100. (City, Town or	Location				10d. Inside City Limi		
Nany To	MARYLAND N/		1X Yas							
- B 5	10e. Street and Number			TIMORE			10g. Citizen of V	Vhat Country?		
r tems 23s or 28s-1s internal be notified.	2018 SWANSEA	RD.		212	239		U.S.A.			
The Land	11. Marital Status	12. Was Decedent Evar in Armed Forces?	U,S. 13	. Was Dacedent of H if Yes, specify Cubi	ispanic Origin? (Specify Yes or No				
th and Mantal Hygiena. 7 is marked other than *natural; or items 23s or 23s-f show traumetic event, the Madical Examinet must be notified at Taumetic event, the Madical Examinet must be notified at	1 Never Married 2 Married 3 Widowed 4 Divorced		1 Yes 2 No	Specify:	no Hican, etc.)	n, etc.) Black, Whita, etc. Specify: BLACK				
tal Hygiena. d other than "naturn avent, the Maggall Be Completed	15. Decedent's Ed (Specify only highest gre	ducetion and completed)	16a. Dec	edent's Usual Occup e kind of work done	ation	ndrina	16b. Kind of Bu	siness/Industry		
npie	Elamentary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retire	1)					
Cor Branch	12th	N/A	UP	HOSTERY	WORKE		UPHOST			
marked off	17. Father's Name (First, Middle, Last)		CMIT			me (First, Middle				
d Men	MELVIN RAL 19a. Informant's Nama/Relationship (SMIT	H iling Address (Straat	ELEA		WIGGI			
T is r	MELVIN SMITH-			8 SWANSE		D BALTO				
of Haai item 2 other	20a. Mathod of Disposition		Place of Dis	position (Neme of		Data		City or Town, State		
- 7	1 Burlal 2 Cremation 3	Removal from State	cemetery, cr	amatory or other ple						
Department Important: I any injury o phos.	4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer			CREMATOR 22. Name and Addre	co of English			sville, Md.		
Depa my i		RONALD GRAY	SQN		RO			FUNERAL SE		
	23a, Part1. Entar tha disaase, or com shock, or heart failure. List only	Transon		312 LIBI				1244 Approximata		
op physician and as the buriel-transit	Immediate Causa (Final disease or condition resulting in death) SEIZURE DISORDER Due to (or as a consequence of):									
physician and is the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):									
	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
d by the attending etached for usa a Physician/M	Part li. Other significant conditions o		sulting in tha	23b. Did	3b. Did tobacco use contribute to the cause of de					
				10	1 Yes 2 No 3 Probably 4 Unkr					
cata has been signed by the a page 2 should be detached Completed by Physic						24a. Was	an autopsy ormed?	24b. Wara autopsy tindin available prior to completion of cause		
10 N D						12	Yes 2□No	of death?		
this certificate heral director, page:	DE Mas accomplement to marked						77	VAJ Tes 2LI No		
rector rector	25. Was case raferred to medicel examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient 23	Z ER/Outpati	ent 3 DOA Oth	or:	eath (Check only		- /Canaikil		
rthis or and direction of the Co.	27. Manner of Death	Home 5 ☐ Rasi	how injury occur							
th. : Aftar a funer ation:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation									
Director Director I in by the ertifica	3 Suicide 6 Could not b 4 Homlcida datarmined	28f. Location (City or To	Street end Numb wn, Stata)	er or Rural Routa Number,						
within 24 hours after death. To the Funeral Director: After to complately filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Ph (Check only 2 Medicat Examone)	ysician: To the bast of my kr niner: On tha basis of examir and manner stated.	nowledge, dar nation and/or	ath occurred at tha ti investigation, in my o	ma, data and place pinion, daath occ	ce, and dua to tha curred at the tima,	causa(s) and ma date and place,	nner as stated. and dua to the ceuse(s)		
To the	29b. Signature and titla of cartiller	M. 14		29c. Licens	o.C.M.F	Ξ.	29d. Data signed March 2	d (Month, Dey, Year) 2, 2000		
X	30. Name and address of peleon who			e, Print) L1 Penn St	reet Ra	altimore	Marvila	nd 21201		
Ctoto	31. Date filed (Month, Dey, Year)	32. Registrar's Signature			LCCC, DC	A. CHIOLE,	, rangina	INA CIGUI		
State Registrar	MAR 2 4 2000	perus p	. 196	all						



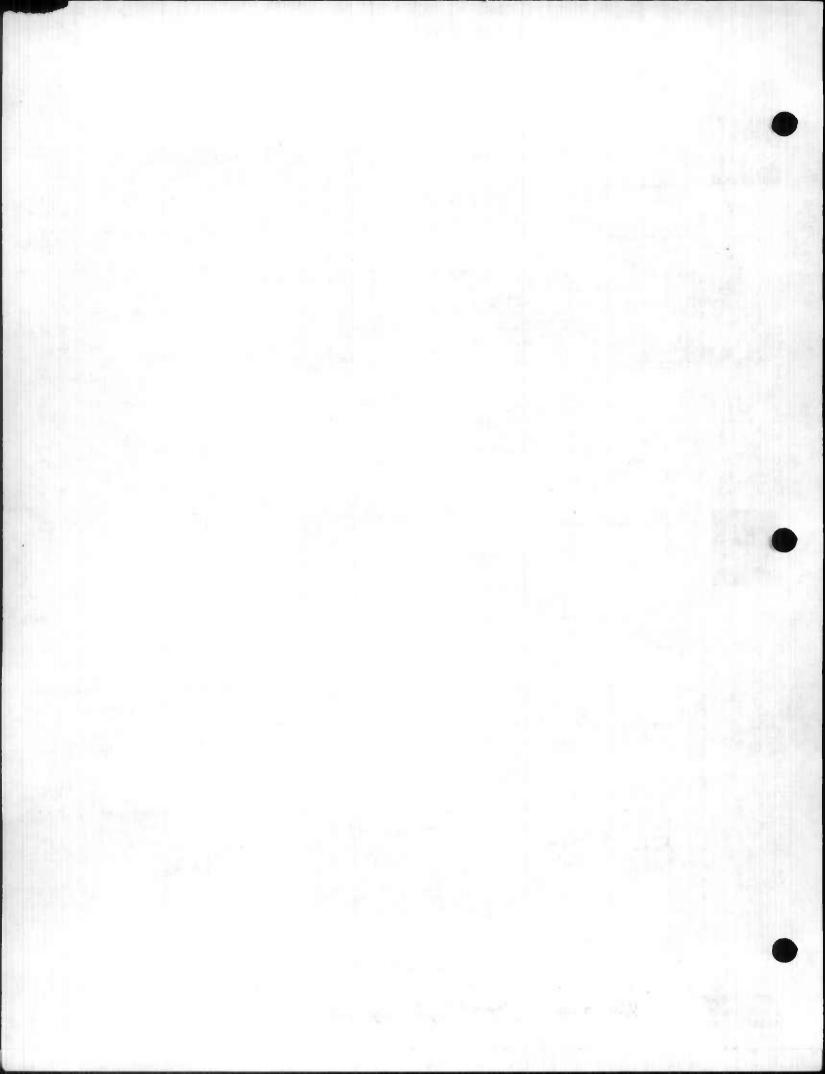
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State of Maryland / Department of Health and Mental Hygiene

					Certific	cate of	Death		Reg. No.	0	0000	
		me (First, Middle, L						2. Date of De Month	eth Day	Year	3. Time of Dea	
ysician Iedical	Syl	via L.	Schwan				11.11	MARCH	18, 20	000	9:42 P	
aminer			ive street and number)					Location of Death				
			General			lada d Vana	Colum			ward		
eral ctor	5. Social Security 555-52 Usual Residence	-7206	Sex 7. Ag	ge (In yrs. last		Inder 1 Year oths Days	If Under 24 Hr. Hours Min		1939 4, 1939	9. Birthplac Country Utah	ce (State or Fo	
	10a. State	10b. County		10c. City, T	own or Location	n				10d	J. Inside City Li	
rector	MD	Howar	d	Col	Lumbia						1 ☐ Yes 2X	
100	10a. Street and N			001		f. Zip Code			10g. Citizen of	What Country	17	
O is	9439 B	rett La	ne			21045	5	3-14	USA			
by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:				in U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexicen, Puerto Rican, etc. 1 Yes 2 No Specify:					or No- 14. Race - American Indian, Bleck, Whita, etc. Specify: White		
ted	100	15. Decedent's E	Education	1	6a. Decedent's	Usual Occup	ation	artina	16b. Kind of B	usiness/Indu	stry	
Completed	Elementery/Sec	condery (0-12)	College (1-4or	5+)	life. DO N	OT use retire						
Co			2	A	dminis	trati	ve Ass			ation	1	
To Be		First, Middle, Las						ame (First, Middle,		n <i>e)</i>		
If item 27 is marked other than or other traumatic event, the M To Be Comp		P. Simon						beth Wa	Wach			
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-8500	Tho		Tupor		299	Free	derick	ety of Rd. Bal	Ltimore	and, i	Inc. 21228	
aminer	Sequentially list of	conditions,	l b. ———	Due to (or as a consequence of): Due to (or as a consequence of):								
the burdet-transit	Sequentially list of any, leading to ceuse. Enter Unc Cause (Disease of that initiated even	1(5	c	Due to (or as	e to (or as a consequence of):							
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	resulting in deeth		0.		7	-						
	resulting in deeth	ificant conditions	contributing to death b	ut not resultin	ng in the underly	ying ceuse gi	ven in Pert I.	23b. Dld	tobacco usa co	ontributs to t	he cause of de	
	resulting in deeth	ificant conditions	contributing to death be	Ven	ous T		ven in Pert I.		tobecco uss co Yes 2□ No		1 1	
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pleted by Physician/M	Pert II. Other sign	ft L	contributing to death be	Ven	ous T			1 D	Yes 2 No an autopsy ormed?	3 Proba	e autopsy findinable prior to pletion of ceus sath?	
Be Completed by Physician/M	Pert II. Other sign C.G.	ft Li crebra	contributing to death beg Deep I Hen	Ven	ous T	Throm	bosis	1 🗆 24e. Was perfo	Yes 2□ No an autopsy ormed? Yes 2□ No	3 Proba	e autopsy findinable prior to pletion of ceus sath?	
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2015	1. Deceden	's Neme (First, Middle, L	nst)	l kei	Cer	tificate of	Death	2. Date of D	Reg. No.		me of Death
Physician		Clifton C.		Jr.				Month	Day	Year	
Medical xaminer	An English t	Name (If not institution, g		, 01.	-		4b. City, Town, or	MARCI Location of Dea			50 PM
		lla Maris					Towson		Ba1	timore	
1			Sex 7. Ag	e (in yrs. las		If Under 1 Yea Months Days	r If Under 24 Hrs	8. Dete of Birth (Month, Day, Year) 9. Birthplace (State Country)			itata or Foreign
		36-0901	ALM ZUF	62	Yrs.			JAN 9,		Maryla	
	10a. State	10b. County		10c. City,	Town or Lo	cation				10d. Ins	ide City Limits
THE PER	MD	N/A		Ra	ltim	ore				1 5	Yes 2□ No
Clanto	10e. Street			Du	101111	10f. Zip Code			10g. Citizen of	What Country?	
i	4301	Glenmore	Avenue			2120			USA		
	11. Meritel S		12. Wes Decedent Armed Forces?	The Late of the La	13. V	Was Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	ipecify Yes or N to Rican, etc.)	o- 14. Rac Bla	ce - American Indi ck, White, etc.	an,
-		er Married 2 Married owed 4 Divorced	1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:	No	1	☐ Yes 2☐N	Specify:		Specif	Black	
		15. Decedent's E	ducation		16a. Deced	lent's Usual Occ	upation		16b. Kind of B	usiness/Industry	
- C. L.	Elementa	(Specify only highest gry/Secondary (0-12)	ade completed) College (1-4or 5	5+)	(Give lite. L	kind of work don OO NOT use retir	e during most of wo ed)	rking			
	12	2			0r	derly			Hospi		
	17. Father's	Neme (First, Middle, Las							e, Meiden Sumer	ne)	
		fton C. Sp							gelett	0	
		ent's Neme/Reletionship					et and Number or Ri enue Re				
	20a. Method	of Disposition		20b. Plac	oe of Dispo	sition (Name of		Date	,	- City or Town, Str	
		rial 2X Cremation 3 netion 5 Other (Spec				netory or other pi ematory.	Inc. 3/2	2/00	Balti	imore,	MD
any injury or other bonce.		of Funeral Service Lie			ress of Facility.						
	E	dward A.	regorchi	k	20	9 Fred	erick Ro	ly OI I	Marylar timore	MD212	2.2
	23a. Part1.	Enter the disease, or oor or heert failure. List ont	1 4	the death.						Appro	ximate al Between
	31lock,	or neer tanore. Est on	ONE CAUSE OF SECTION	110.							end Deeth
	disease or o		LUNC	G CANC	ER						
-	resulting in	oeam)		Due to (or a	s a conseq	uence of):			_		
Examiner			b	D	o e sinale					1	
		y list conditions, ng to immediate or Underlying		Due to (or a	s a conseq	uence or):					
	Cause (Dise	ease or injury	C	Due to (or a	a a conseq	uence of):				1	
	Tooming it	Consul, East	4								
1			d.					4.9.			
	Part II. Othe	r significant conditions	contributing to death b	ut not resulti	ng in the ur	nderlying cause of	given in Part I.	23b. Did	I tobacco uae co	entribute to the ca	nues of death?
								1	Yas 2 No	3 Probably	4 Unknown
									s an autopsy	24b. Were aut	
								peri	ormed?	available completic of death?	on of cause
								10	Yes 2 No	1 ☐ Yea	2□ No
	25. Was car	ne referred to medical					26. Place of De	eth (Check only	one)		
)	examine 1 🗆 Yes		Hospitel: 1 Inpatie	ent 2 EF	- VOutpatien	t 3 DOA	ther: 4 Nursing I	forme 5□ Res	idence 6XIOth	ner (Specity) H (SPICE
			28a. Date of Inju (Month, Day	ry y Year) 21	8b. Time of tnjury	28c. Inj		28d. Describe	how injury occur	rred	
Certification:	2 ☐ Acc		20				☐ Yes 2 ☐ No	not to a time	(0)		- M - L
	4 □ Hor	datarmina		ury - At home c. (Specify)	e, farm, str	set, factory, office	9		(Street end Numi own, State)	ber or Rural Route	9 Num <i>ber</i> ,
		r 117 Certifying P	hysician: To the best of	of my knowle	edge, death	occurred at the	time, date and place	and due to the	cause(s) and m	anner as stated.	
edical	(Check one)		miner: On the basis of and manner sta	examination	and/or inv	restigation, in my	opinion, deeth occi	urred at the time	, date end place,	and dua to the ca	luse(s)
Me		ure end title of certifier				29c. Lice	nse number		-	ed (Month, Day, Y	ear)
		-/n	-			Dy	3725		3/2	1/00.	
	30. Neme ar	nd address of person who	completed cause of d	eath (Item 2	3a) (Type,		401				
		TARIQ MAHM				LEY RD.	TIMONIU	M, MD 2	1093		
ate	31. Date file	MAR 2 4 200	O 32/Registra	ar's Signatur	9.	Sparks					
gistrar						1					

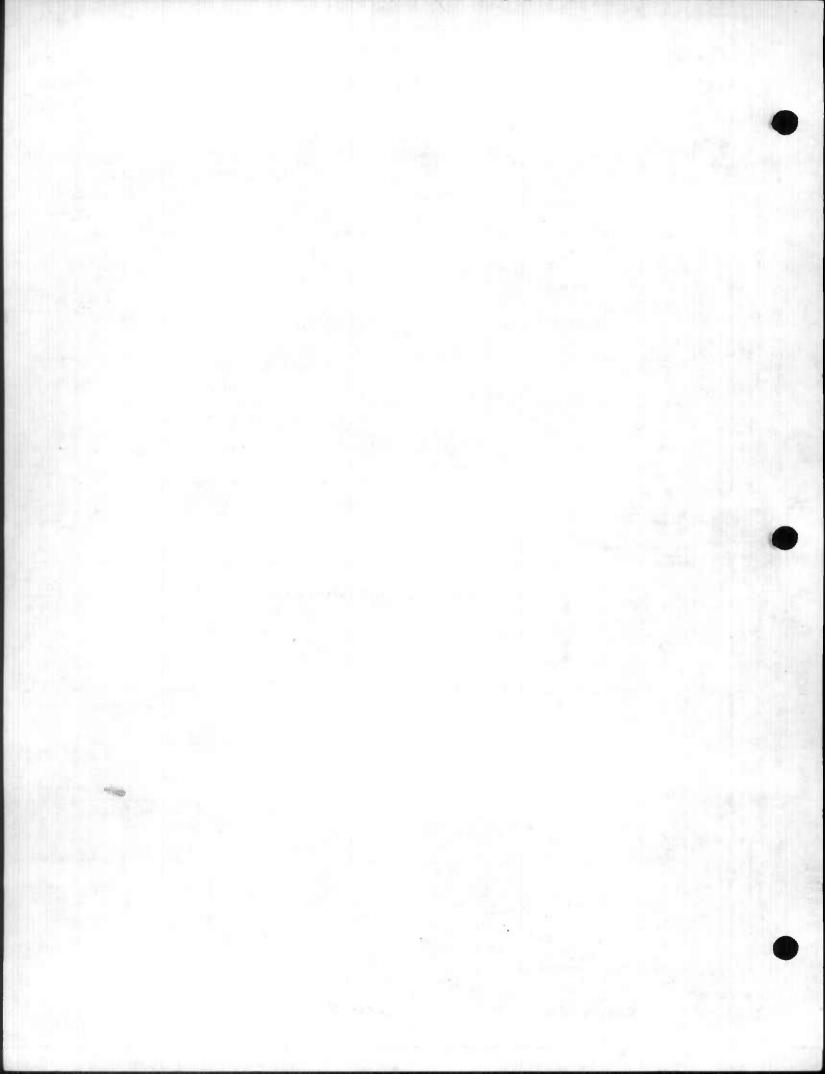


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death 05.20 Am March 21, 2000 **Physician** Margaret Mary Sanders /Medical 4a Facility Neme (If not institution, give street and number) b. City, Town, or Location of Death Examiner Agnes Health care Baltimore If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 20 F Director 219-18-5550 April 2, 1925 MD Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 288-4 MD. Baltimore, 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? b 3310 Benson Ave. 21227 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 8 1 Yes 2 No Specify: 21215-0020 Specify: à 3 Widowed 4 □ Divorced Year or Detes: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 Nursing Aide Hospital Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Timothy Allen Mary Catherine O'Shea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) nt of Health a If from 27 to or other tra James C. Sanders Son Parksley Ave. Baltimore, MD. 21223 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 03/24 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc. Lours 736 Edmondson Ave. Baltimore, Md. 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on aech line. Approximeta interval Betwe Onset and Death **Physician** immediate Cause (Final diseasa or condition resulting in death) /Medical Examiner Due to (or as a consequence of): meta MAR Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disaase or injury that initiated evants resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): Physician/M Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy lindings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 ☐ No 1 Yas 2 No Vital 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA to # 27. Mennerof Death 28a. Date of injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affair 5 Pending investigation Division 1 Naturai 1 ☐ Yas 2 ☐ No 2 Accident after death Director: 6 Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of injury - At home, larm, street, factory, office building, atc. (Specify) 4 Homicida ò Hospital a Funeral o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Cartifier Medical (Check only one) To the Y 29c. License number 29b. Signeture end little of cartifier 29d. Date signed (Month, Dey, Year) M.D. March 21, 2000

State Registrar

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)
Mustapha Mallah 900 Caton Avenue Baltimore, MD 21213 31. Dete liled (Month, Day, Year) MAR 2 4 2000 32/Registrar's Signature



10f. Zip Code

21229

1 Yas 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Agnes

Physician /Medical Examiner

ST. AGNES

5402 Frederick

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Fether's Neme (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

4

20e. Method of Disposition

William

10b. County

15. Decedent's Education (Specify only highest grade completed)

Shaffrey

William Shaffrey/brother

1 ■ Burial 2 □ Cremation 3 □ Ramoval Irom State

5. Social Sacurity Number

10e Street and Number

11 Marital Status

10a. State

Md

219-20-6331 Usual Residence of Decedent

KOSPITAL_

1 M 2 F

Avenue

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give

Year or Dates

College (1-4or 5+)

7. Age (In yrs. last birthdey)

10c. City. Town or Location

Baltimore

Clerk

20b. Place of Disposition (Neme of cematery, cremetory or other place)

New

Cathedral Cem

736 Edmondson Avenue, Ba

KESPIRA

Due to (or as a consequence of):

Due to (or as a consequenca ol)

Due to (or as a consequence of):

28b. Time of

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

TRICTIVE

SEVERE

22. Nama and Address of Facility

BALTIMORE

| H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 9 1 2 1 9 1 7

18. Mother's Neme (First, Middle, Maiden Sumeme)

Date

3/28

Sterling-Ashton-Schwab Funeral Home,

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

5402 Frederick Ave, Balto, Md 21229

Kelly

DISEASE

10.26 A

10g. Citizen of What Country?

14 Race - American Indian

T. Rowe Price

White

Black, Whita, etc.

USA

Specify

16b. Kind of Business/Industry

20c. Location - City or Town, State

Baltimore, Md.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Balto,

Birthplaca (State or Foreign Country)

MD

10d. Insida City Limits 120 Yas 2 □ No

Inc

21228 Approximate Interval Between Onset and Death

Hours

EARR

CONGENITAL

24b. Ware autopsy findings available prior to

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

Funeral Director

Director Funeral 70 Completed

Be

Pages 1 and 2 should be filed within 72 hours in nort of Health and Mental Hyglene. Int: If Hern 27 is marked other than "natural", o Department of important: If 8

21215-0020

Baltimore, Maryland

Physician /Medical Examiner

The law requires that the death certificate be executed pue Box 68760, physician the for use signed by the a P.O. Records, certificate NAME Division of Vital

To the Hospital o within 24 hours at To the Funeral Di completely filled is State

aptital or Attending Physician: Theoris after death.
Ineral Director: After this certificate by filled in by the funeral director, pa

21. Signature of Ferieral Service Licensee Examiner Physician/Medicai Be Completed by Certification: To 27. Menner of Deeth 29a. Certifiar edicai

tmmediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. PNEUMONIA 25. Was case referred to medical

1 Yes 212 No

5 Panding

investigetion 6 Could not be determined

1/ Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

CONGESTIVE

28a. Dete of Injury (Month, Day Year)

UEART FAILURE

26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28c. Injury at Work?

UNG

KYPHOSCOLIOSIS

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28d. Describe how injury occurred

24a. Was an autopsy performed?

1 ☐ Yes 2 No

29b. Signature and title of certifier Vasantha (cumas mi) 29c. License number D42510

tize Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

29d. Date signed (Month, Dey, Year) MARCH 23RD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. VASANTHA KUMAR MD

31. Date filed (Month, Dey, Year)
MAR 2 4 2000 32. Registrar's Signeture 821 NEUTAW ST SUITE 407 MO 21201

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 7:30 a.m. Ruth I. Shelleman March 23, 2000 4a Facility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 4310 Glenmore Avenue Baltimore City If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 23, 1923 9. Birthplace (State or Foreign Country) Hagerstown, Md. 7. Age (In yrs. last birthday) Days 1 M 2 X F 76 Yrs 214-14-6947 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Md. N/A BaltimoreCity 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4310 Glenmore Avenue 21206 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indien Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Hubert Moats Mary Leona Gilbert 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles C. ShellemanJr. (Stepson) 6703B Washington Blvd. Arlington, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 3/27/00 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee Milton J. Knight Jr 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 HarfordRoad Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that counsed the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on the online. Approximate Interval Between Onset and Deeth Immediate Ceuse (Finel a METASTATIC CANCINUM LUNG TEM disease or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? HYPERTENS10N 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical exeminer?

Physician /Medical Examiner

pue

Physician

/Medical

Examiner

Director

Funeral

p

Completed

å

2

10e. Stete

Funeral

Director

8 6

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8

Hygiene. Ther then

Pages 1 and 2 should be nent of Health and Mental

nt of Health a : If Item 27 is r or other tra

Department of Important: If any Injury or

filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner the bunal-transit Physician/Medical signed by the at d be detached for Be Completed by Certification: To funeral filled in by

has

certificate

this

The law requires that the death certificate be asscuted

P.O. Box 68760,

Division of Vital Records.

Attending Physician:

To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ANTENIOSCUMOTIC CONDIOVASCIALOR DISEASE

DIABLETES MELLITUS

3 Suicide

29a. Certifier

4 - Homicide

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 25 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 Neturel
2 Accident 5 Panding Investigation 1 Yes 2 No 6 Could not be determined

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signeture and title of certifier

9 - 000

29c. License number 715135

29d. Date signed (Month, Day, Year) MANCH 23, 2000

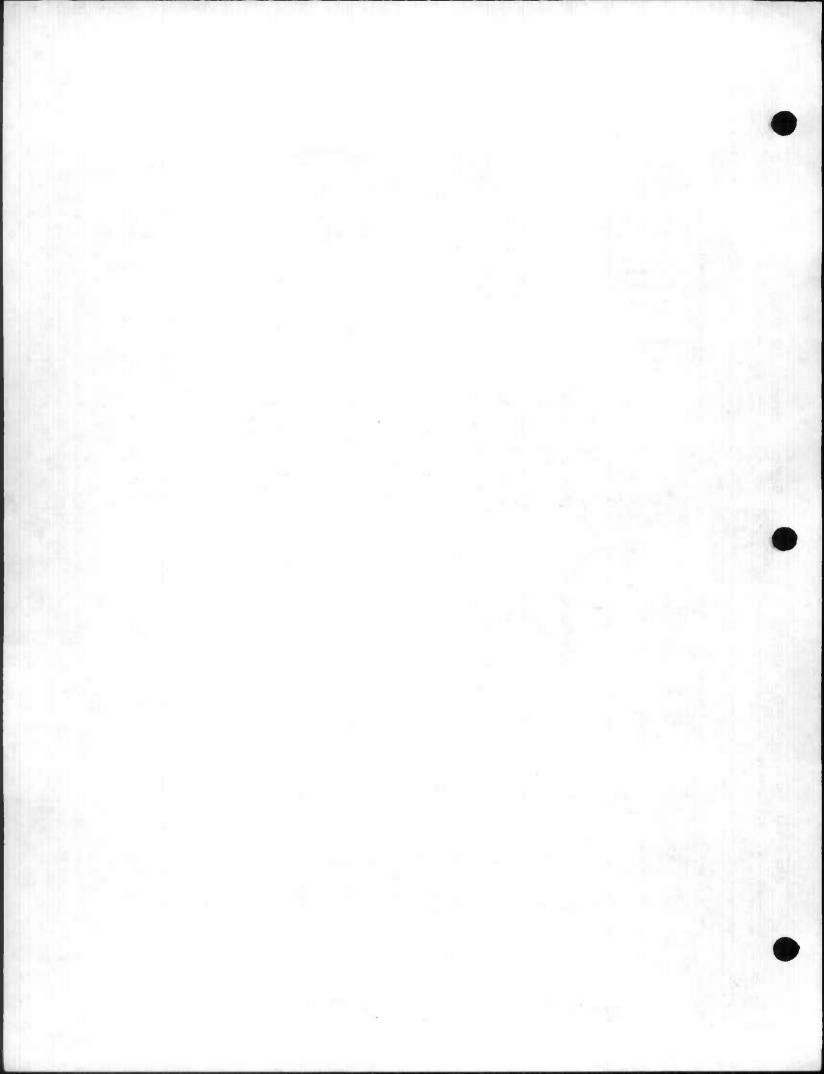
completely

State Registrar

edicai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENSUPE P. SUN MD SON WLY M 31. Dete filed (Month, Day, Year) MAR 24 2000 32. Registrar's Styllature

STON WILL MOUSE BUD SHITEST 2 KNOWNE MD 2125 oorks



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09535 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death /Month Year **Physician** larch 2000 /Medical 4c. County of Death give street and number) Facility Name (If not institution, 4b. City, Town, or Location of Deeth Examiner 6. Sex MUSON If Under 24 Hra. 8. Date imor 8. Date of Birth Month, Day If Under 1 Year Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months -03-730 10M 20 F Hours 212-03-730. Usual Residence of Decedent Director the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hama 23a or 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director Maryland timore OWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Va ney 21 Funeral d 12. Wes Decedent Ever in V,S.
Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian. 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be fled within 72 hours effer inent of Health and Mental hygiene.
Int: If them 27 is marked other than "natural", or Nearly or other traumed event, its health and in a market. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: à 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coljage (1-4or 5+) 6 rar 0 Baltimore, Maryland 17. Father's Name /First Middle Lasti 18. Mother's Neme (First, Middle, Meiden Sumeme) Be waro nnie 19a. Informant's Name/Reletionship (Type, Print) (grand Son 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Peges 1 and 2 is Department of Health or Important: if hem 27 is eny injury or other treu once. nthe 世 12 New YOCK, Vew 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removet from State 4 ☐ Donation 5 ☐ Other (Specify) nea 21. Signature of Funeral Service Vicenters 22. Name and Address of Fecifit meral Balto. Joseph Ave Md. 2121 WiNorth e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. Approximate Interval Between Onset and Death Physician Lilarys /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ician and burlei-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): physician the burlel Box 68760 Physician/Medical Due to (or es e consequence of): 985 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? NEOMONS 1 Yes 2 No 3 Probably MyUnknown Records, by been signe should be Laubre Viceofor C1355 EE Completed 24b. Were sutopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? page 2 1 Yas 200 No 1 Yes 2 No Division of Vital Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Gursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No ie Hospital or Attendit in 24 hours stier deeth. Ne Funeral Director: A pletely filled in by the fi 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Cartiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) Registrar

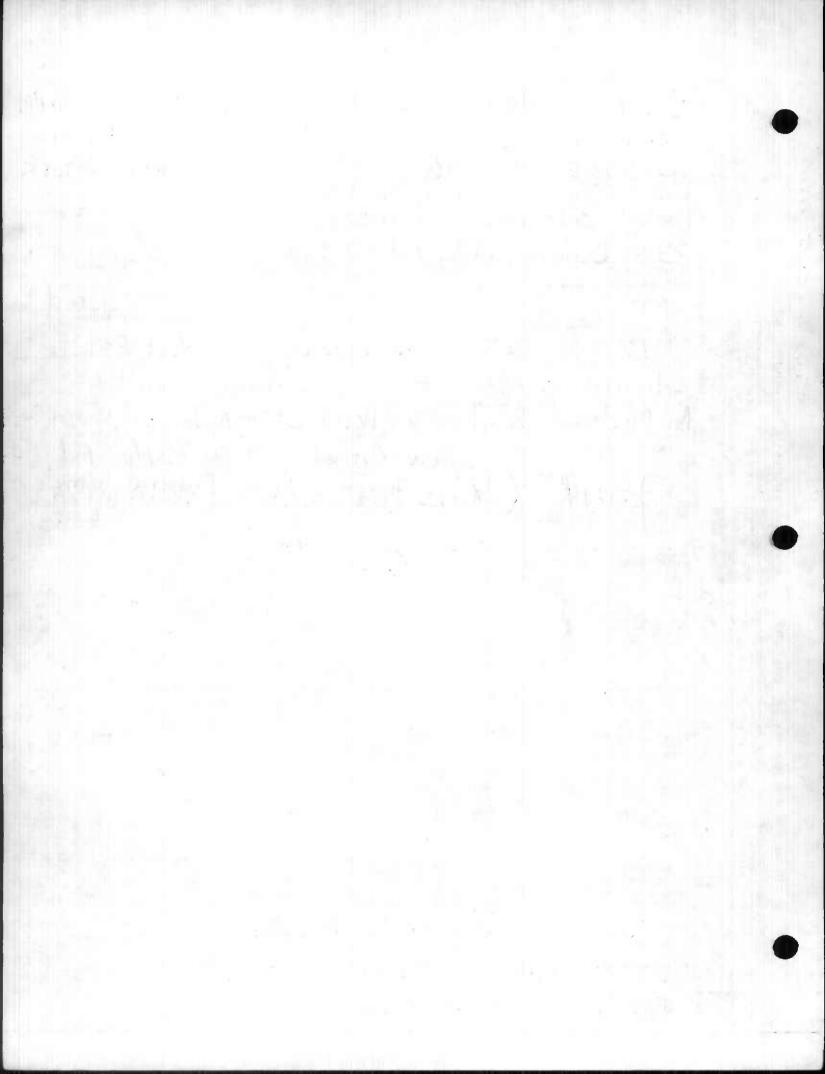
mpleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signeture

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3/23/0



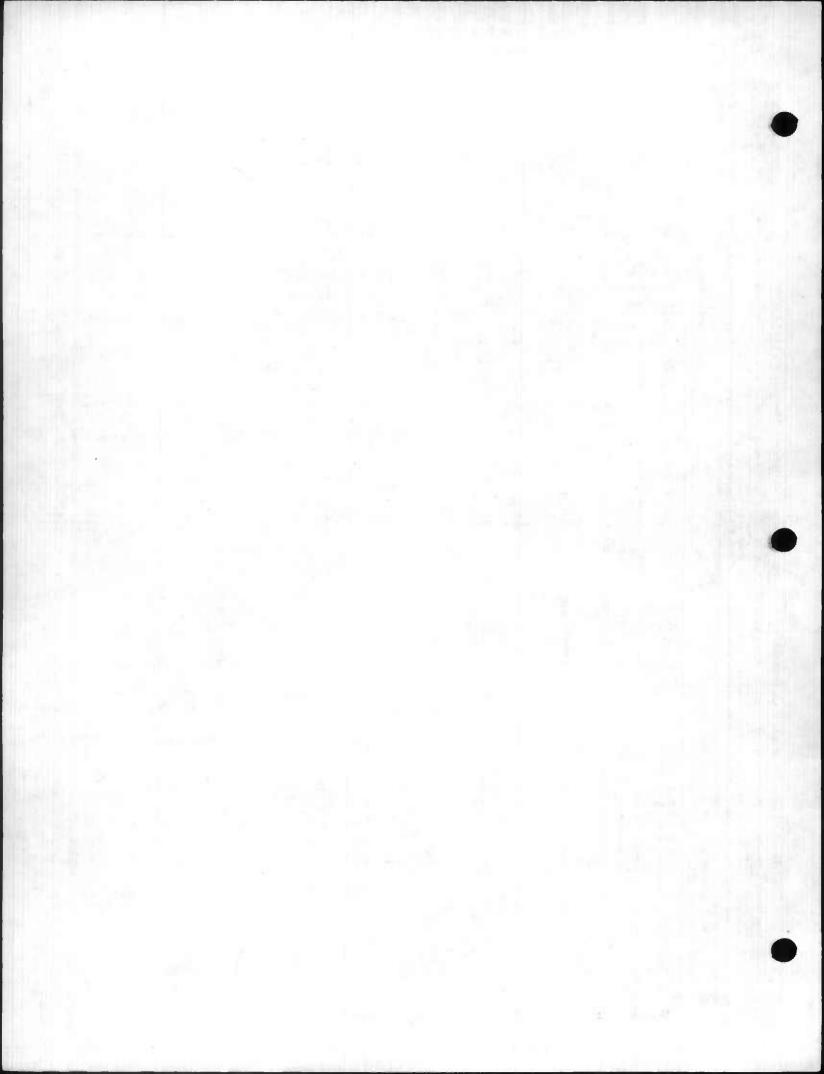
Registrar

State

31. Date liled (Month, Day, Year)
MAR 2 4 2000

32. Registrar's Signature

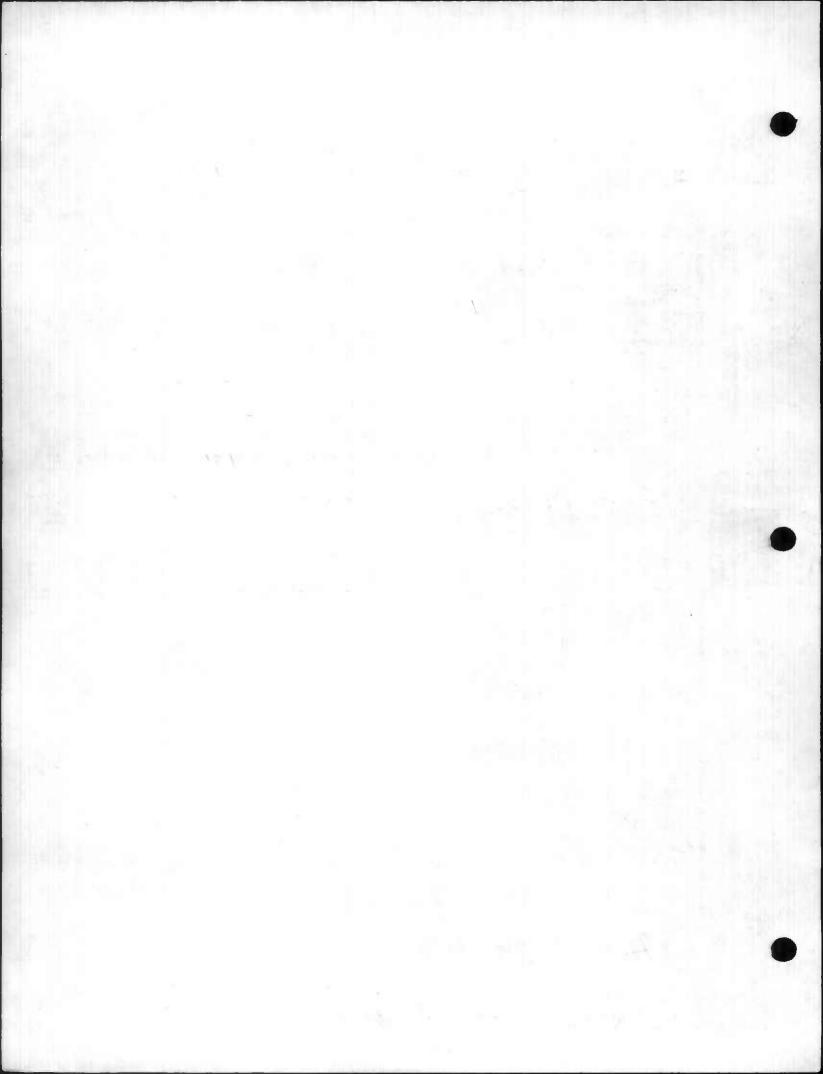
111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

							C	ertifica	e of	Death		Reg. F	No.	U I	093	031
		п	1. Decedent's Nam	ne (First, Middle, I	.ast)						2. Dale o	of Death			3. Time	of Death
	Physici		LARRATUT OTTOUAUTT CUARTO										Yeer	11.	15 PM	
	/Medic Examin	de Facility Name (Mant factivities are street as deported)									4c. County		44.	IJ FM		
	Examili										Cecil					
	Funeral		5. Social Security		Sex	7. Age (In yrs			r 1 Year	If Under 24 h		of Birth		9. Birtho	oiaca (Sta	te or Foreign
	Director		219-70-17	110	10 M 20 F	39	Yrs.	Months	Days	Hours N	fin. (Mont)	1, Day, Yes 27/60	er)	Cour	ntry)	RE, MD.
			Usual Residence of			1 27					112/	27/00	1	DILL	1 11101	(C) 1110 .
	of M	L.	10a. State 10b. County 10c. City, Town or Location									1		City Limits		
	Med a	tor	MD.			1	RAITTM	OPF							XXDY	es 2 No
	or 28e-f	Directo	MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Wha								/hat Cour	ntry?				
	38 o															
	death Tree 2	Funeral	11. Marital Status	III SLIKK	12. Was Dec	edent Ever in	U,S. 13	3. Wes Dece	dent of h	Hispanic Origin?	(Specify Yes	or No-	_	- Americ	can Indian	
2 0	after or the	2	X X Never Man	ried 2 Merried	Armed F 1 ☐ Yes	2 No	No				uerto Rican, etc					
PHYSICIA HORTS 21215-0020	Ser.	by	3 Widowed 4 Divorced Year or Detail 84			ive 0\$10:184	4 1 Yes 2 No Specify:					Specify: BL:			K	
200	2 ho	To Be Completed		15. Decedent's	Education		16a. Decedent's Usual Occupation						16b. Kind of Business/Industry			
SHORTS 1 21215-0020	Tu and		(Spec	cify only highest g		1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)									
	The state of		12	sidely (0-12)	College	1-401 5+)	CLERK TYPIST						GOVERMENT			
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	hould by d Menta marked matte ev		PAUL HUNTER PAULETTE SHORTS								,					
KNOWN TO INE S. S Maryland	S D D D D D D D D D D D D D D D D D D D		19a. Informant's N		19b. Ma	iling Addres	s (Street	and Number or	Rural Route N	umber, City	y or Town,	State, Zir.	Code)			
	and 2 leafth a m 27 la har tra		PAULETTI	50	1 DOL	PHIN	ST., BA	LTIMORE	, MAR	YLAND	212	17				
NAME KNO LORRAINE Imore, Mar	T Head		20a. Method of Disposition 20b. Place of Disposition (Name of Dete 20c. Location - C)	
NAME LORR More	A DE TO		VN□ Buriat 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)										MITI	10	MD.	
-	The state of		21. Signature of Funeral Service Licenses											IVILL	LS,	1410.
Baltir	Dep		11	ESTEP BROS, FSPA 1300 EUTAW PLACE, BALTO, MD 17												
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			23a. Part1. Enter the disease, or complications that calculate the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.										1		Between	
	Physician		Onset and Deeth											nd Deeth		
	/Medical Examiner		Immediate Cause (Final disease or condition a. Dehydration											3 da	vs	
	LAUTITICI		resulting in death) Due to (or as a consequence of):										-1-			
	P ==	Examiner				Acquire	ed Imm	une De	fic	iency Sy	vndrome			i	20 mc	onths
	and tran		Sequentially list conditions, if any, leading to immediate													
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68760,	# F#	edical	that initiated events resulting in death) Last Due to (or es a consequenca of):													
Ø	attending p	2														
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<u>.</u>	the at	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use confi									fribute to the cause of death?				
9.	at the de	P.	1 Yee 2 No								2 No	3 Probably 4 1 Unknown				
Ś	es the debed	by				-					_			-		
P	been si should	8										Was an au		24b. W	ere eutop	sy findings
0	aw requisite been 2 should	Completed									-	porionino		00	mpletion death?	
æ	The la	E										1 🗆 Yes	2√No	11	☐ Yes :	2□ No
<u>a</u>			25. Was case refer	red to medical						OC Diseased I	Death (Check o		X		J 165 4	20 140
5		To Be	axaminer?		Hospital:	Inpatient 20	☐ ER/Outpati	ient 3 D	Ott	oer.			0 700	- (0	4.3	
o	a Physer this		27. Manner of Deat		-		28b. Time		-		g Home 5 28d. Desc		njury occurre		ny)	
on	After fune	to	1 Matural	5 Pending investigeti		of Injury oth, Dey Year)	Injury	M	28c. Inju Wo	rk? Yes 2 □ No			, , , , , , , , , , , , , , , , , , , ,			
S	deati deati	Ca	2 ☐ Accident 3 ☐ Suicide	6 Could not	be Die	e of Injury - At I	home form				28t Locat	inn /Street	end Numbe	er or Run	el Route A	lumbar
Division of Vital Records, P.O.	5 4 5 5	Certification:	4 Homicide	determine	build	ing, etc. (Spec	ify)	311001, 100101	y, omoo		City o	r Town, St	ete)			
	Par Sura	2	29a. Certifier	100 Cartifidae D	husisian. To the	hast of my lin	audadaa da	oth converse	at the ti	ma data and at	and due to	Abo nove	(a) and ma		Antad	
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	To the comple	ž.	29b. Signeture and	title of certifier	and mar	mer steted.		20	c Licens	se number		204 [Dala signad	/Month	Doy Yes	el
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	30		30. Name end addr	ess of person who	completed cau	sé of deeth (Ite	em 23a) (Type	e, Print)								
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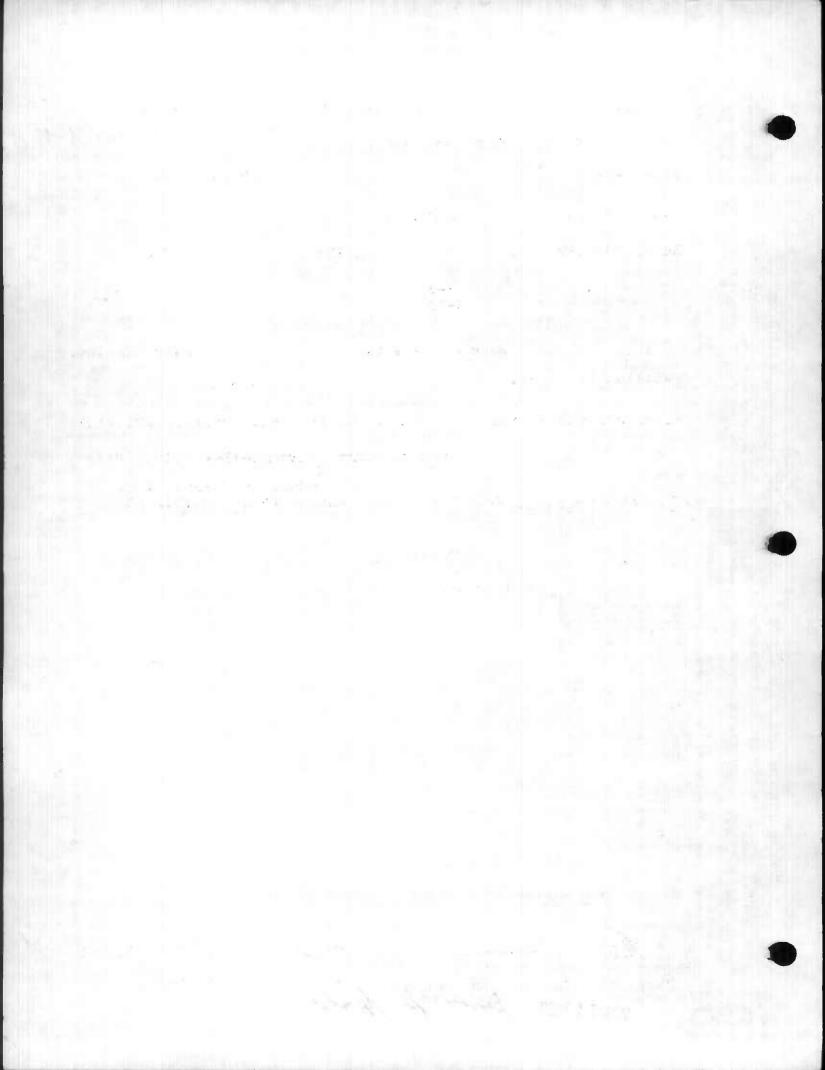


State of Maryland / Department of Health and Mental Hygiene

AMEND#23 PER MD. G781 3-24-2000 JAB Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 12:35 am 6,2000 SMITH March WILLIAM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner Baltimore City Baltiman de Veterans Hospital Baltmane Administration 7. Age (in yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthpleca (State or Found)
 Country) 5. Sociel Security Number 6. Sex **Funeral** 1**X** M 2□ F Months Deys Hours Min. 49 Yrs Director 218-56-0233 Usual Residence of Decedent MD 2 1951 Mar. the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No MD NA BALTIMORE Directo 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? With 34 N. WHEELER AVE. 21223 USA death Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexicen, Puarto Rican, atc.) 14. Race - American Indian, permit. Pagas 1 and 2 should be filed within 72 hours after c Department of Haelih and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or iten any injury or other treumatic event, the Medical Examinants. Bleck, White, etc. 1 Yas 2 No 7-68 If Yes, Give Year or Dates: 8-69 1 Never Marriad Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) College (1-4or 5+)
2 Vears Elementery/Secondary (0-12) years Painter Self- Employed 17. Fether's Nema (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maidan Sumeme) Be William Smith Jr. Helen Vaughan 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Frances Smith - Wife 34 N. Wheeler Ave. Balto. MD 21223 20b. Plece of Disposition (Name of cemetary, crametory or other plece) 20c. Location - City or Town, Stete 20e. Mathod of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Veterans 3-13-00 Owings Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MARCH FUNERAL HOME WEST, INC. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. BALTO., MD 21215 Approximate Intervel Between Onset and Death **Physician** Medical Immedieta Causa (Final Hemorhage disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner Gastrointestal Hemorrhage certificate be executed physician and s the burial-trans Sequantially list conditions, if any, laading to immediate ceusa. Enter Underlying Cause (Diseasa or Injury that Initiated events resulting in daath) Lest Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): use as for detached 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Division of Vital Records, P.O. signed by t 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown P 24b. Wera autopsy findings available prior to Completed 24e. Was an eutopsy performed? completion of ceuse of death? page 2 has 2 No 1 Yas 2 No certificata 1 Yas 25. Wes cese rafarred to medical axaminar? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No P this funeral 27. Menner of Deeth 28a. Deta of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? After Certification: 1 Natural
2 Accident or Attending 5 Pending investigation s after deeth. 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specity) In by 4 Homicida Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the causa(s) and manner es stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted. 29a. Cartifian Medical completaly (Check only one) within 2 \$ 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signetura end titla of certifier 0 MD P13363 March. 6,2000 30. Name and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Baltimore, MD 21201 Bran Martin Alan South Greene 32 Aegistrer's Signetura 31. Date filed (Month, Day, Year)
MAR 2 4 2000 State Registrar

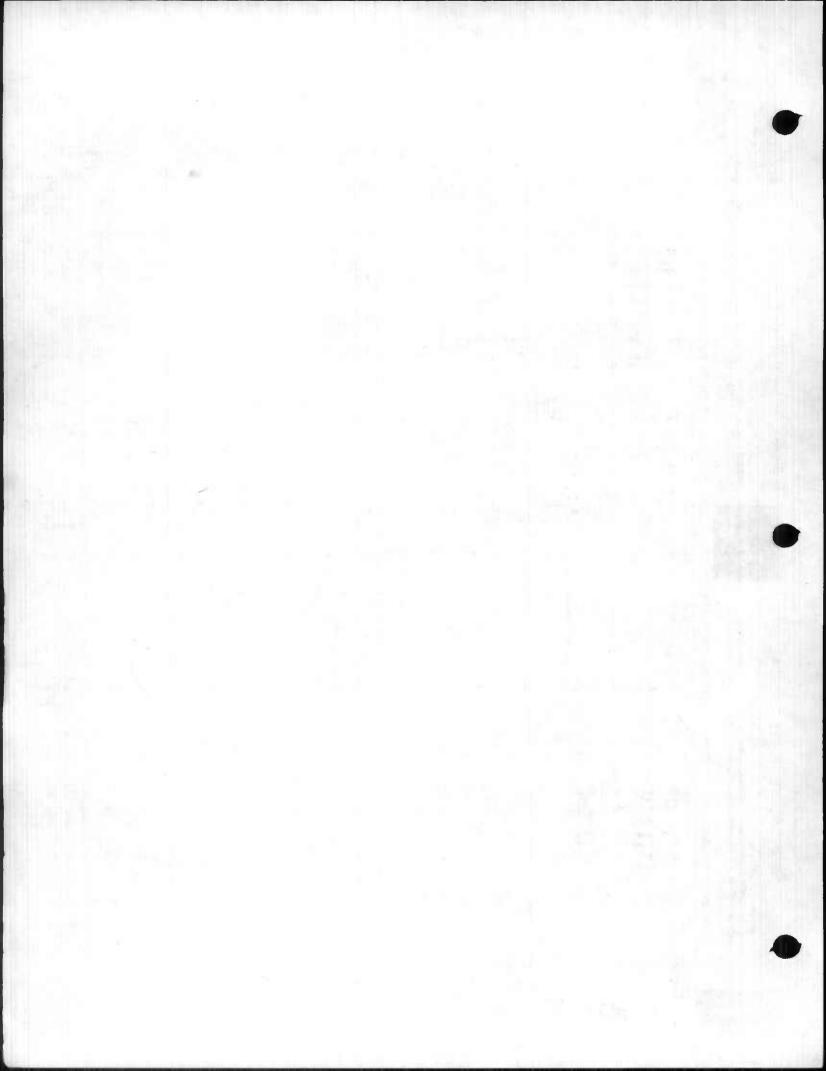
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #19b PER FH G781 3/24/2000 AH 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Thurman Shiflett 2:00am March 18 2000 /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forest Haven Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Hours Yrs. 79 Director 219-01-0452 June 20, 1920 W. Virginia Usuel Residence of Decede 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director or 28a-f MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 234 1260 Sugarwood Circle Unit 103 21221 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 8 1□ Yes 2X No 21215-0020 Specify: Specify: à 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondery (0-12) College (1-4or 5+) Crane Operator 6 altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 2 should be fi and Mertal F 88 Thomas Shiflett Lois Munday Pages 1 and 2 should nant of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 19e. Informent's Neme/Reletionship (Type, Print) nt of Health a Hillsem 27 is or other train Bryan Shiflett- Son 4 Randy Frost Court Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Laurel, Maryland 3/19/00 Balto. Wash. Crematory 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Charles S. Zeiler & Son, Inc 6224 Eastern Avenue Baltimore, lesseuth Maryland 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or neer failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical neumonia Examiner Due to (or as a consequence of): Examine Acciden ere bro vascular The law requires that the death certificate be executed shysician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Aortic Box 68760, physician Stenosis Physician/Medical Due to (or as a consequence of) for use as Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. be detached 1 Yes 2 No 3 Probably 4 Unknown heart þ 24b. Were autopsy findings sysilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Medicai Certification: To Be Completed page 2 1 Yes 2 No 1 Yes 2 No of Vitai Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpetient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) s after death. Il Director: After this ed in by the funeral d After this 28c. Injury et Work? 27. Menner of Death 28d. Describe how Injury occurred Attending 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be

Division 6 Hospital 24 hours

To the Hospital within 24 hours a To the Funeral L completely

filled in by

homas 31. Date filed (Month, Day, Year) State Registrar

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chiorzi

mo

MO-051811

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Day, Year)

Rd Baltimore MD 1120 N. Rolling

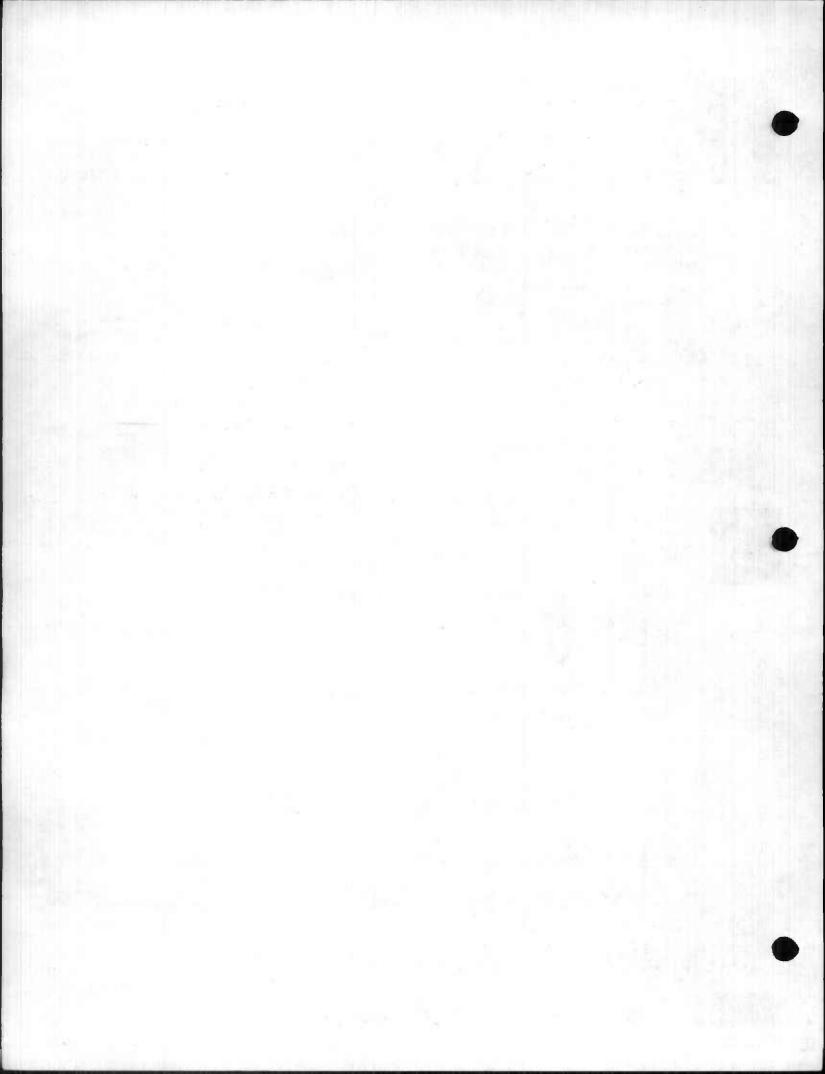
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

32 Registrar's Signature MAR 2 4 2000

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene 09541 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Data of Death 3. Time of Death Month **Physician** 2000 03/ 17/ 4:25 PM THOMAS STOKES TEMPLETON /Medical 4a. Facility Nama (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mitchellville Prince Georges Villa Rosa Nursing Home If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number If Undar 1 Yaar 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1₽M 2□F Days Yrs. Director 144-03-9032 Usual Rasidanca of Dacedan 89 01-22-1911 North Carolina the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Mod cal Examiner must be notified at 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Director Prince Georges New Carrollton 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? permit. Peges 1 and 2 should be filled within 72 hours after death 1 Department of Health and Mental Hygiena.
Important: If hem 27 is marked other than "nature." 20784 USA 8320 Nicholson Street Funeral 12. Was Dacedant Evar In U,S. Armed Forcas? 1√JYas 2 □ No tkYas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 11. Marital Status 14. Race - Amarican Indian Black, Whita, atc. 1 Navar Marriad 2 Marriad 1 ☐ Yas 2 ☑ No Specify: Specify: White à 3 □ Widowad 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Elementery/Secondary (0-12) Collaga (1-4or 5+) 5+ Attorney Law 11 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middla, Maiden Surnama) Be Leia Belle Redmond Rutherford Sumner Templeton 19a. tnformant's Name/Ratationship (Type, Print) 19b. Maiting Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Betty Templeton wife 8320 Nicholson Street New Carrollton, Maryland 20784

20b. Place of Disposition (Nema of camatary, cramatory or other place)

Baltimore Washington Crem. 20a. Mathod of Disposition 1 ☐ Burial 2 € Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) 03-21-00 Laurel, Maryland 22. Nama and Addrass of Facility Fleck Funeral Home, Inc. ease, or complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

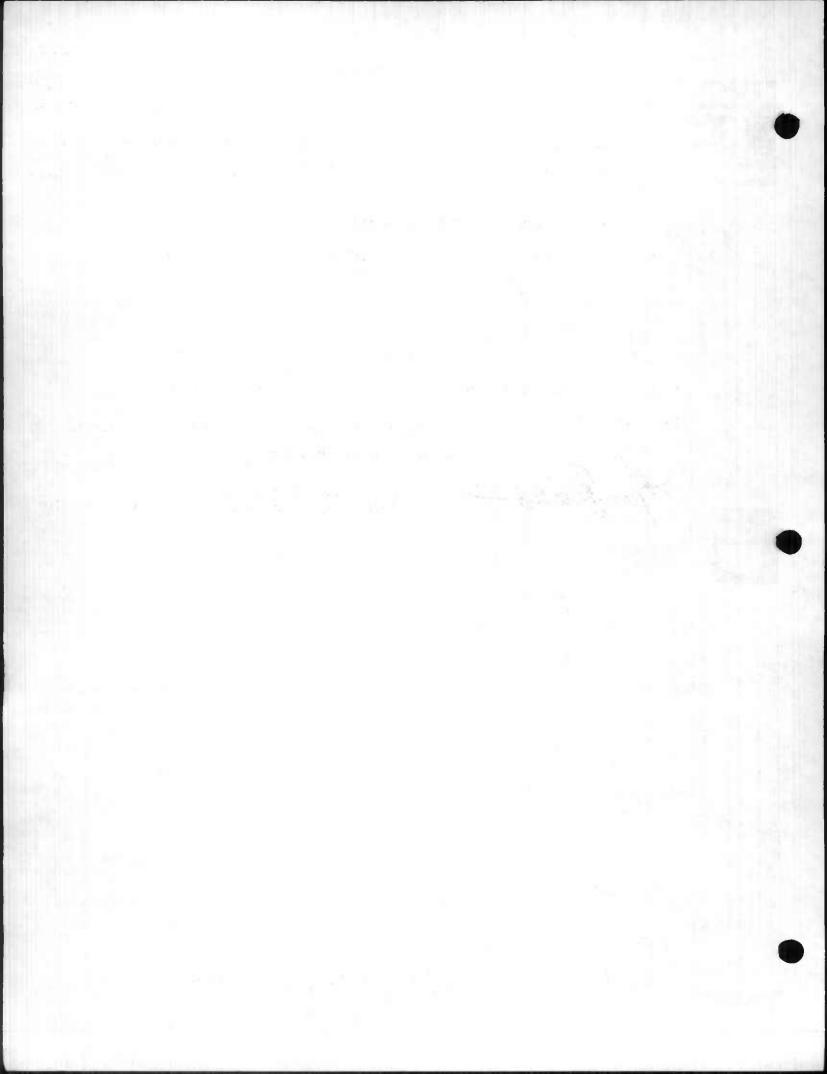
ADDITION ADDITION TO THE PROPERTY OF THE Approximata intarval Batween Onsat and Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Examiner Examiner attending physician and for use as the bunal-transit certificata be executed Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avents rasulting in daath) Last Dua to (or as a consequance of) P.O. Box 68760 hromboaytopenia Physician/Medical Dua to (or as a consequence of): signed by the at Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Records. by cata has been significant page 2 should b 24b. Ware autopsy findings available prior to Completed 24a. Wes en eutopsy complation of ceusa of death? certificata has 1 Yas 2 No 1 Yas 2 No Division of Vital 25. Wes cesa rafarrad to medicet axaminar? Be 26. Piece of Death (Check only ona) Othar: 4 Nursing Homa 5 Rastdance 6 Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatlant 3 ☐ DOA After this funerai 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: Attending 5 Panding invastigation 1 Naturat injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yas 2 ☐ No 2 Accidant filled in by the 3 Suicida 6 Could not be datarminad 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Phyalcian: To tha best of my knowledge, death occurred et the Ilma, deta and place, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On tha basis of examinetion end/or invastigation, in my opinion, death occurred at the time, dete and place, and dua to tha ceuse(s) end mannar statad. edical 29a. Certifia: completaly 29b. Signatura and titta of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) R066055 3-17-00 30. Name and eddress of person who completed causa of daath (Itam 200) (Type, Print)

Fig. - L. (Rallimur 4734 Pullar Rd. Shady Side, Md-20764 31. Data filed (Month, Dey, Year)
MAR 2 4 2000 32. Registrar's Signetura State

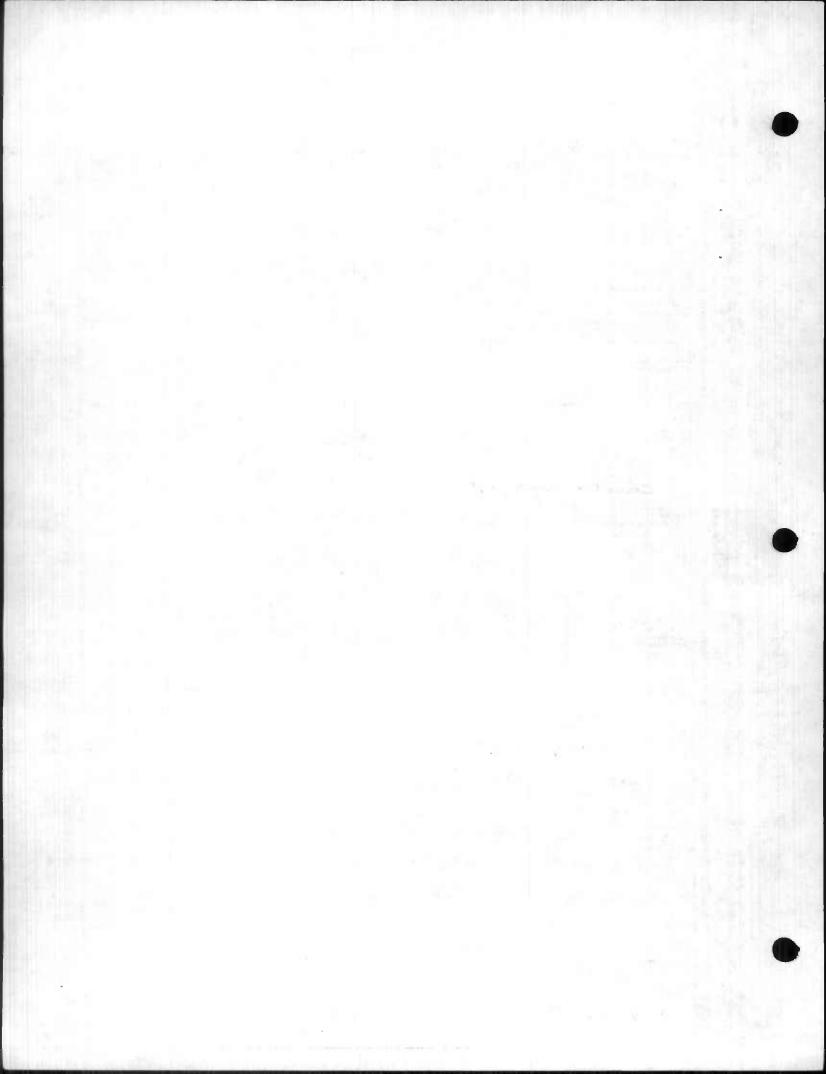
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygien® 0 051.2

ician	1. Decedent's Nam	ne (First, Middle, L	ast)				Death	2. Date of De			3. Time of Death	
	Beverly Beaman Traynum							March	22, 20	Yeer	9:10 A	
dical niner			ive street and number				4b. City, Town, or				J.IU A	
	Genesi	s Multi	-Medical				Towson		Bai	ltime	ore	
	5. Social Security I			ge (In yrs. lasi	birthday)	If Under 1 Yeer Months Days	If Under 24 Hrs	8. Dete of Bir (Month, Da			lace (Stete or Foreign	
r	212-22- Usual Residence of	1400	1□ M 2√F	82	Yrs.	Monins Days	Hours Miri.	OCT 10,	1917	Ohic		
	10s. State 10b. County 10c. City, Town or Location									1	0d. Inside City Limits	
to	MD	Baltin	nore	35	Balt.	imore				1 ☐ Yes 2 No		
5	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen of	itry?		
9	6409 CI	loister	Gate Dr:	ive		21212			USA			
by Funeral Director	11. Marital Status 1 Never Man	ried 2 Merried	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No		/as Decedent of Yes, specify Cub ☐ Yes 2 ☐ No	Hispanic Origin? (Sean, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rac Ble Specifi	ce · Amaric ck, White, by: Wh		
9	/Sno	15. Decedent's E		1	6a. Decede	ent's Usuel Occu	pation during most of wo	rkina	16b. Kind of Busing		dustry	
Completed	Elementary/Sec		College (1-4or	5+)			d)	in ing				
S	12				Home	emaker				n Ho	me	
B	17. Father's Name		1)					me (First, Middle,		ne)		
2								nel Davis				
	Judith K	lame/Relationship (antt/da			19b. Meiling Address (Street and Number or Aural Route Number, City or T 6409 Cloister Gate Dr., Balt							
	20a. Method of Dis			20b. Piec	e of Dispos	ition (Name of etory or other pla	cel	Dete	20c. Location	- City or To	wn, State	
	1 ☐ Burial 2 4 ☐ Donation	□Cremetion 3 I 5 □Other (Speci	Removel from State	matory,	3/00 Baltimore, MD							
	21. Signature of	uneral Service I ice	77900	0								
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest. Approximate interval Beh											
	23a. Pert1. Enter I shock, or hea	the disease, or con art tailure. List only	nplications that cause y one cause on each	d the death. I	Do not ente	r the mode of dy	ng, such as cardia	c or respiretory a	rest,		Approximate Interval Between	
	week regions a love			i	Onset and Death							
	Immediate Cause (Final disease or condition Silent Arry Thinia									1	liwides	
-	resulting in death)		Λi	Due to (or as	e consequ	ience of):	Δ .	- 1				
Examine			b. Anten	osden	hi (browany	Arteny	Disea	re		years	
XB	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):											
8	Cause (Disease or	erlying r injury	c									
P	resulting in death)	Last		Due to (or as	e consequ	ence of):				j		
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ā												
-	Dort II Other elect	ficant conditions	contributing to death	but not resultin	g in the und	derlying cause gi	ven in Part I.	23b. Did	lobacco use co	ontribute to	the cause of death	
ysio	ratii. Ouler signi										habby 4 1 Hakaou	
Phy	ratii. Odor signi	Demen	ta					10	Yes 20 No	3 Pro	SEDIY 4 DONAIGI	
5	ratii. Ould agii	Demen	ta									
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by		Atrial	Fibrillat	ron				24a. Was	en autopsy	24b. W	era autopsy tindings	
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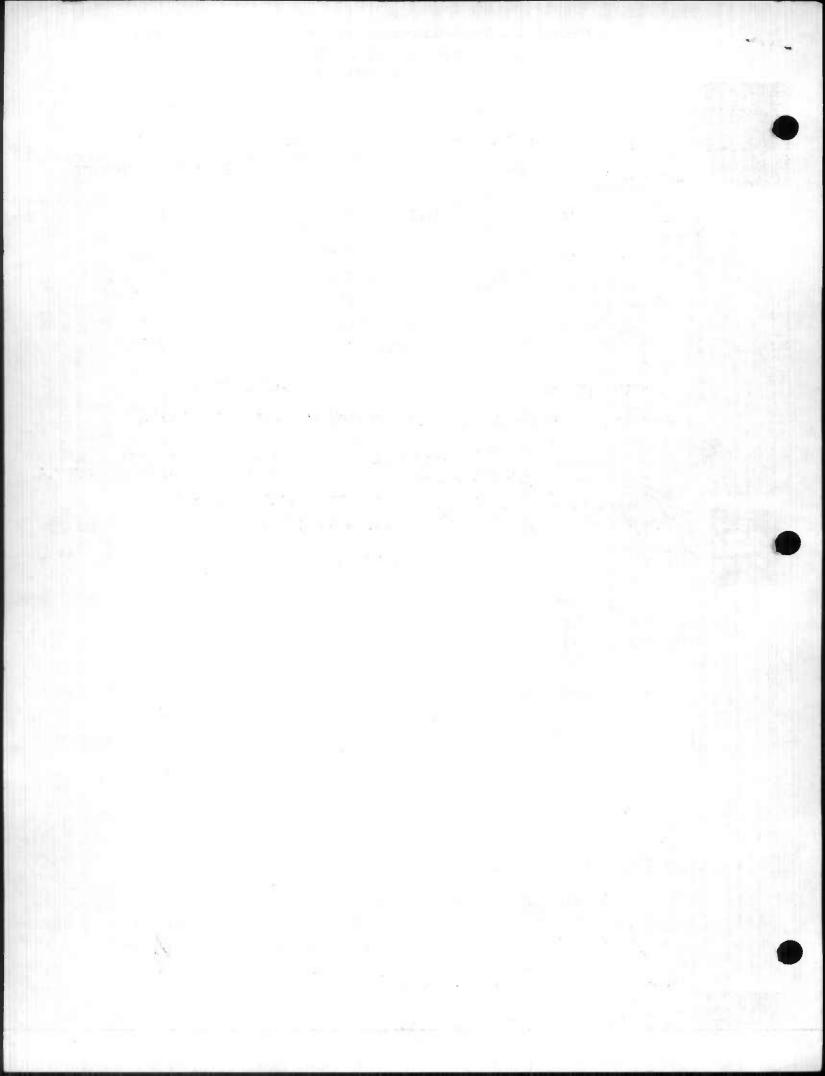
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 3 16 - 2006 **Physician** 4:35 PM CHRISTINE TEEL /Medical 4b. City, Town, or Location of Death 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BALTIMORE GENESIS HAMILTON NURSING HOME If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Sociei Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 10 M XXF Months VIRGINIA 86 Vrs Director 299-12-6719 Usuel Residence of Decedent the Marylend 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at BALTIMORE Yes 2 No N/A Director 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 21206 U.S.A. 5903 RADECKE AVE. Funeral 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritel Status 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 SpeciBLACK 1 ☐ Yes XXNo þ XXWidowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 in and Mental Hygiene.
7 Is marked other than "ne Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be MARTHA WRIGHT CHRISTOPHER WRIGHT 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If item 27 is any Injury or other trau 5766 CEDONIA AVE. BALTIMORE MD 21206 MARGARET YOUNG (DAUGHTER) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burlai 2 Cremetion 3 Removel from Stan 3-18-2000 CATONSVILLE METRO CREMATORY 21. Signature of Funeral Service Licens of LUGENE 22. Name and Address of Facility ESTEP BROS FUNERAL SERVICE P.A. N 1300 EUTAW PLACE BALTO MD 21217 23a, Part 1. Enter the disease, or complications that eaused the de shock, opticart failure. List only one cause on each line. Do not enter the mode of dylng, such as cardiec or respiretory errest, Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final Marol , Secs Examine Due to (or es e consequence of): Examiner physicien end the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) Box 68760 Physician/Medical Due to (or es a consequença of) attending P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No signed by 3 Probably 4 Unknown Division of Vital Records. by 24b. Were sutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy Completed page 2 1 Tes 1 ☐ Yes 2 ☐ No certificete Active Nopital or Attending Physician:
with 24 hours after deeth.

To the Funeral Director: After this certific
completely filled in by the funeral director. 26. Place of Deeth (Check only one) 25. Wes cese referred to medical exeminer? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide Certifying Physiciag: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es ateled.

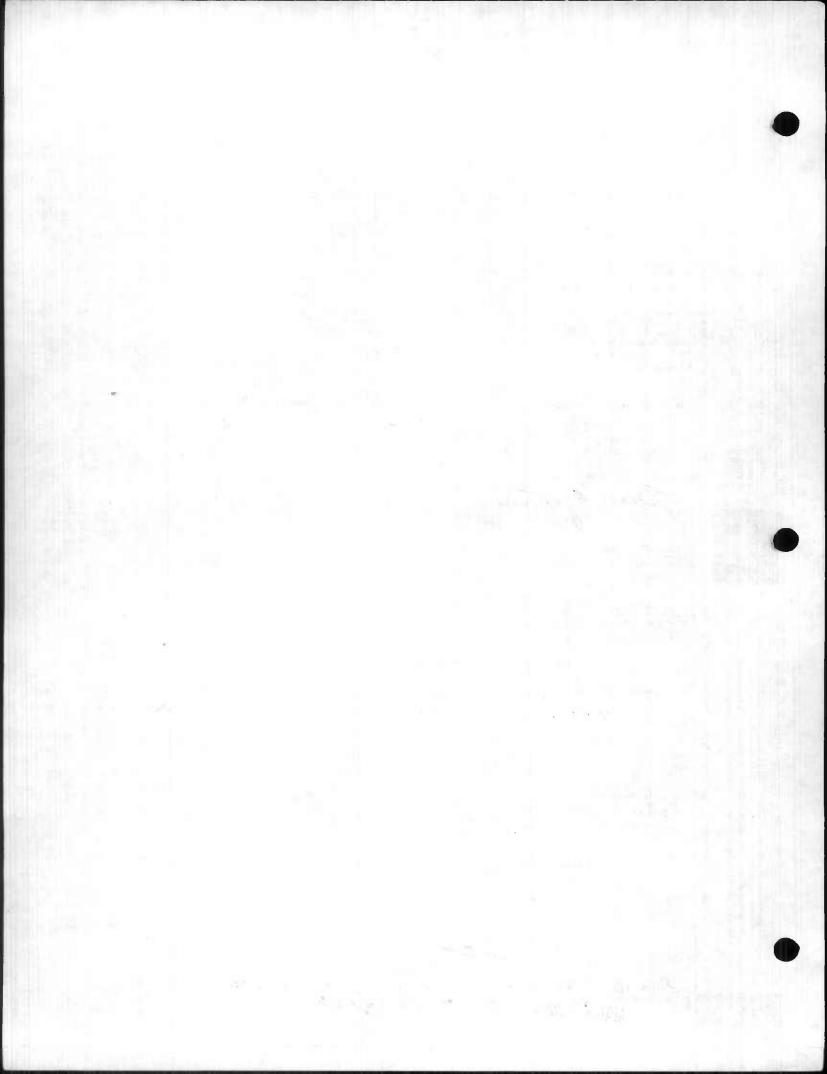
On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner stated. Medical 29e. Certifier 29b. Signeture en title of contilin 29c. License number 29d. Dete signed (Month, Dev. Year) 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 17 FOWTANA LANE, SUITE 105, BALT. MO. 31. Per- mich (Month, Day, Year) 32. Registrer's Signature State MAR 2 4 2000 Registrar

DHMH 16 Ray 6/95



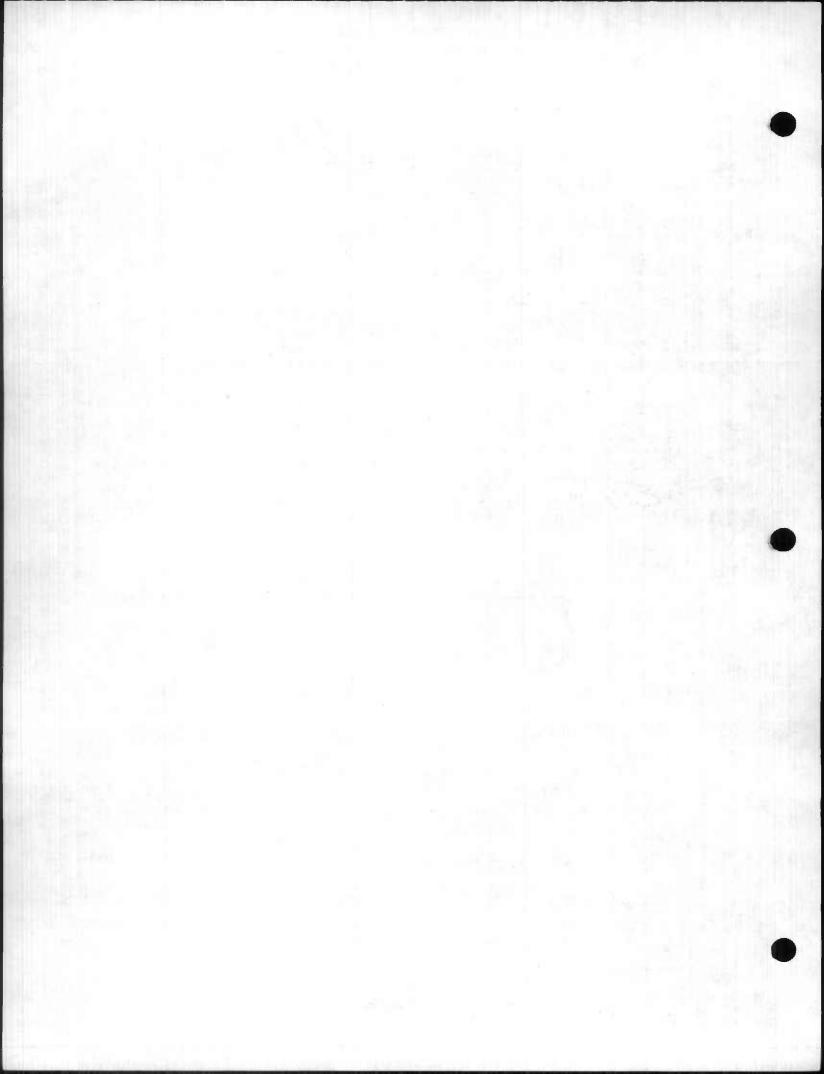
State of Maryland / Department of Health and Mental Hygiene

sician					Cei	rtificate	e of l	Death		Reg. No.) ()	9544	
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		MARYLAND GENERA		7				BALTIMOR			NA		
ral tor	2		Sex 1 M 2 F	Age (In yrs. 67	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Data of Bi	ay. Year) 3-32	9. Birthplac Country	MD	
	-	. Stata 10b. County			10d	Inside City Limits							
rector		MD NA	ltimo	own or Location timore					1⁄2 Yas 2 N				
Funeral Director	10e.	Street and Number 524 Robert St		10f. Zip	Code	7		10g. Citizen of What Country? USA					
by	:	Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yas 2	1 ☐ Yas 2 ĀNo				ispanic Origin? (S In, Mexican, Puer Specify:	pecify Yes or No Rican, etc.)	as or No- etc.) 14. Race - American Indien, Black, Whita, atc. Specify: Black			
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S	1	lth Grade	NA		Нои	ısewi	fe			in ho			
8	17.1	Father's Nama (First, Middla, Las	1)						me (First, Middle, Maiden Surname)				
2		Clarence				Mable	3	Irby					
		. Informant's Name/Ralationship			19b. Meilir	ng Address	(Street	and Number or R	ber, City or Town, State, Zip Code)				
		Susan L. Tayl	lor		535	Robe	rt	Street	Baltin	nore, M	D. 2	1217	
once.		. Mathod of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Con		a	tace of Dispo emetery, crem LYY1SC	natory or of	ther plac		Data ∋m. 03-	20c. Location - 27 – 200			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day **Physician** Turnbaugh March 16, 2000 Margaret 11:26PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph's Hospital Baltimore Towson If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 KF Yrs. 216-36-4783 88 Director Oct.27,1911 Balto.MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show. or 28a-f sh a notified. 1 Yas 2 No Directo Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Berns 23a 14 Northwood Drive 21093 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Raca - American Indian, Was Decedent of Hispanic Origin? (Specify Yea or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Merried "natural", or I Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyplens. other than Elementary/Secondary (0-12) College (1-4or 5+) 7 yrs. Housewife N/A Home Department of Health and Mental Hyp Important: If them 27 is marked other any Injury or other trausment other angles. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be William George Knight Mary Catherine Stump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7719 Buck Hill Road Mildred Darney (Sister) Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State St. John's Cem. (Sweet Air) 4 ☐ Donation 5 ☐ Other (Specify) 3/20/2000 Phoenix, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.F.Lassahn Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** GASTro INTESTINA Bleeding - a cute /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sician and burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical physic the Due to (or as a consequenca of): 88 980 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? there selectic Chrolis upsales deserve 1 Yaa 2 No 3 Probably 4 Unknown Records, by The law requires 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vitai or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 PER/Outpatient 3 DOA After this funeral 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident within 24 hours after deal To the Funeral Director: 8 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide To the Hospital ACCONTINING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of cartifier 29c. License number MANYLAN 54 Scott Adam Road Suite 202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AWTENCE BOAS Cockeysville, MD. 21030 32 Begistrar's Spnature 31. Date liled (Month, Day, Year) State 2 4 2000 Registrar



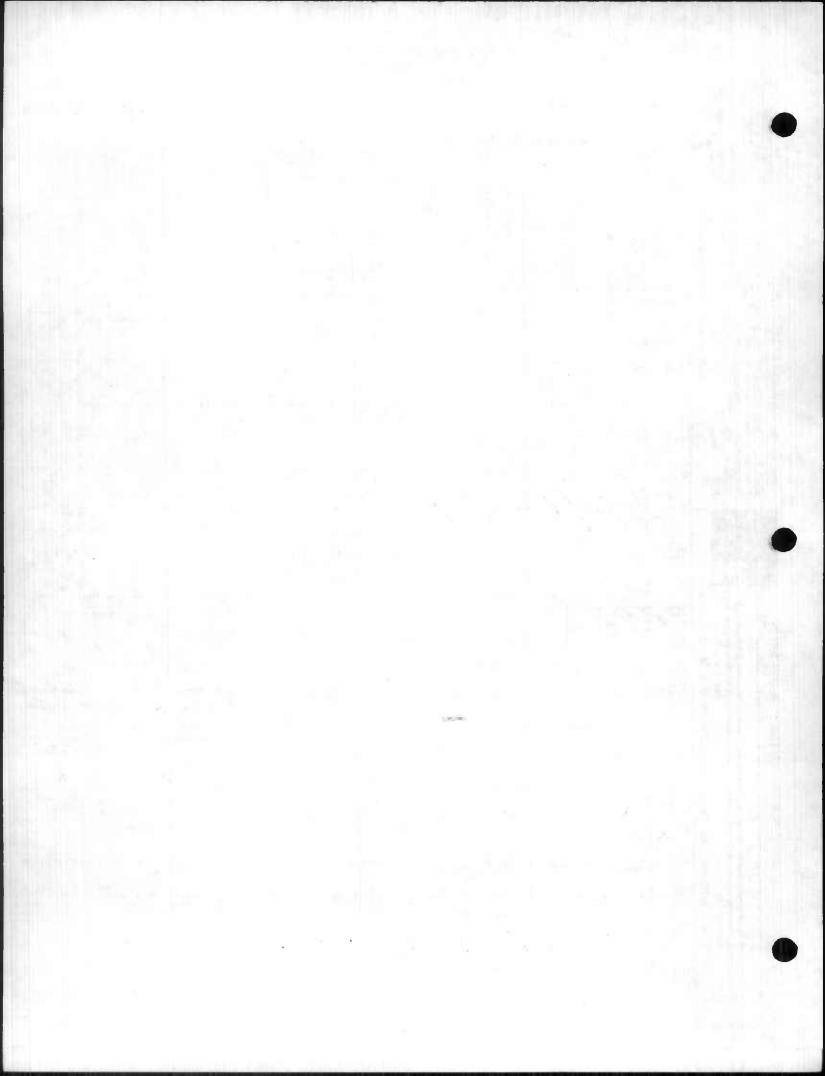
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 19546 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** Baby Boy White 13 2000 5:10pm /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Battimox Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 F Hours Country) MARYLAND NONE Yrs. Director Usual Residence of Dacedeni 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or frems 23s or 28s-f show ent, the Medical Examinar must be notified at MD BALTIMORE 1 N Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 21217 2312 EUTAW PLACE U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 Yas 2 No If Yas, Give Year or Datas: 1 Nevar Merried 2 Merried BLACK altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specific à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mantal Hygiens Important: if item 27 is marked other tha any Injury or other traumatic event, that page. INFANT INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANGELA R. EDWARDS CHARLES W. WHITE, III 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 2312 EUTAW PLACE. 21217 CHARLES W. WHITE, III 20b. Piece of Disposition (Name of cematery, cremetory or other piece) 20e. Mathod of Disposition 03-23 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete KING MEMORIAL PARK WOODLAWN, MARYLAND 2000 4 Donetion 5 Other (Specify) 21, Signature of Funeral Service Licenses 22. Name end Address of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 icultions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel severe Immaturiti etal disaese or condition resulting in deeth) Examiner attending physician and for use as the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events rasulting in death) Lest Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed b Division of Vital Records, b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peed : 1 Yes 20 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical exeminer?
1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospitel:

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in 24 hour. 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29e, Certifier 29b. Signeture and title of certifis 29c. License number 29d. Dete signed (Month, Day, Year) 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) 2411 West Belvedere Ave. Suite 201, Baltimore, Md. 21215 Sally Sondergaard, MD. 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State DOLKS MAR 2 4 2000 22 per Registrar **DHMH 16 Rav 6/95** --- 0 - ---

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vest **Physician** Alice G WILSON 21, 2000 4c. County of Death /Medical March 7.45am 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Agnes Nursing and Rehab Center Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Director 527-03-32 81 March 24,1918 Kansas Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Nama 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 20 No Director Baltimore MD. Catonsville å 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 Edmondson Ave. 21228 USA Funeral filed within 72 hours after death Hygiene. Other than "natural", or items 23 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 No Specify: p 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Benefits Supervisor Social Security permit. Peges 1 and 2 should be filed.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other.
eny injury or other traument. Maryland 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Robert Gilbert Etna Vance 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lowell G. Wilson Son 2903 Fox Fire Ct. Ellicott City, MD. 21042 Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, State competery, crematory of other place)
Meadowridge Memorial Park 03/24 1 Burial 2 ☐ Cremation 3 ☐ Removal Irom State Elkridge, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc. 21. Signeture of Funerel Service Licanses trudy 1400 736 Edmondson Ave. Baltimore, MD. 21228 23a. Part1. Enter the disease, or complications that eased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause of each line. Approximete Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Myocardial Infarction One Day Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Coronary Artery Disease
Due to (or as a consequence of): The law requires that the deeth certificate be executed Years. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or es e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 | Yes 2E No 3 | Probably 4 | Unknown HYpothyroidism of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Senile Dementia page 1 ☐ Yes 2 No 1 Tyes 25 No Physician: Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation Injury s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral C completely filled Medical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Dev. Year) 29b. Signature end title of certifier 29c. License number 40-D 30469 March 21, 2000. 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Registrar

State

B Vellanki

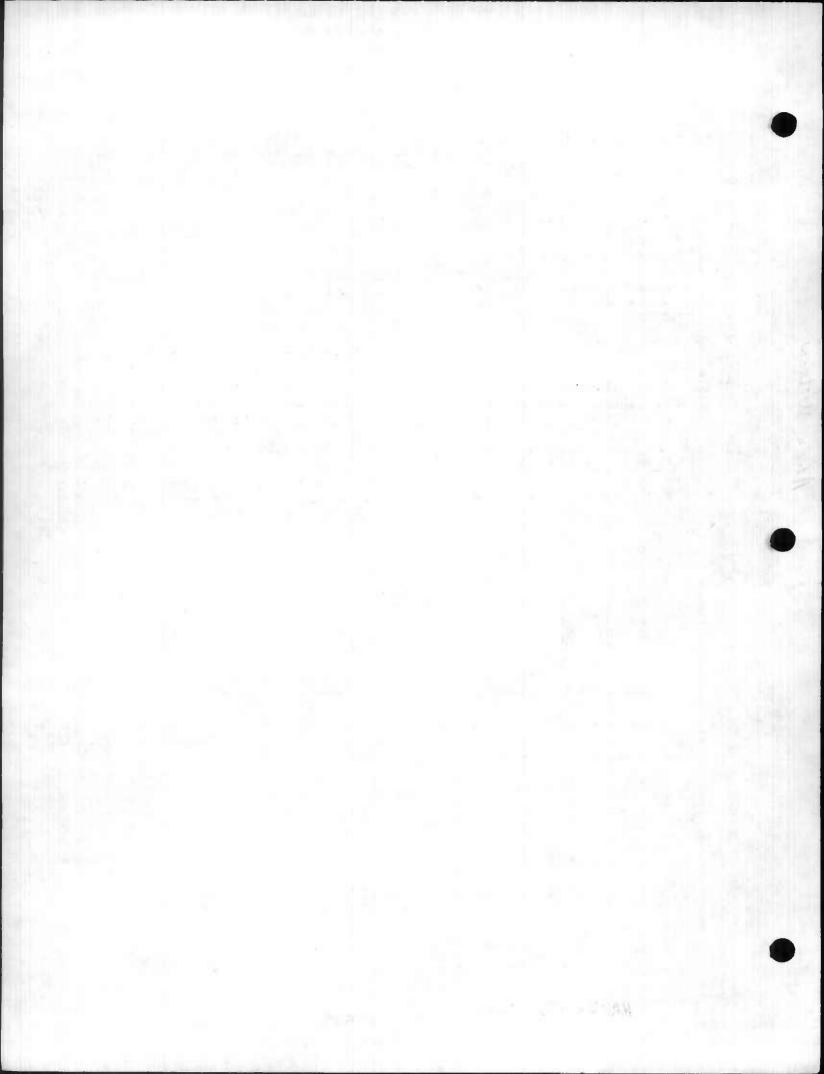
31. Date filed (Month Pag Year) 2000

MD;

32. Registrar's Signature

DHMH 16 Rav 6/95

9055, Chevrolet Drive, #100, Ellicott City, MD 21042,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** Robert Grant Wright, Sr. 2000 1:15 a.m March /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Baltimore N/A St. Agnes Hospital If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dev. Year) 04/28/1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Days Months Hours Virginia 18 M 2□ F 227-22-4567 73 Director Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow man be notified at 1 ☐ Yes 2 No Director Lansdowne Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States 326 Bigley Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Herrs 2 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, 11 Marital Status Black, Whita, etc. filed within 72 hours after 1 ☐ Yas 2 ☒No If Yas, Giva 1 Nevar Married 2 Married 21215-0020 natural, or 1 ☐ Yas 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than "nature traumetic event, to Medical 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Maryland Asphalt Elementary/Secondary (0-12) Collega (1-4or 5+) Highway Inspecter Contracting Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Be Ernest Grant Wright Addie Mae Burnette 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 326 Bigley Ave. Lansdowne Maryland 21227 Marie Jones Wright/wife 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Department of Important: If any Injury or once. Meadowridge Memorial Park 3/24 Elkridge, Maryland 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland, 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaesa or condition rasulting in deeth) /Medical ongestive **Examiner** Examiner Stenosi Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Ceuse (Diseasa or Injury that initiated avants rasulting In death) Last Diseese Coronary Arter Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 20 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Ves 2□ No 117 Yes 2 No 25. Wes casa rafarred to medical axaminar?

1 Pres 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Netural 5 ☐ Pending 1 Yes 2 No death. invastigation 2 Accidant after death Director: 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Funeral D Hospital 29a. Certifier 1 Certifying Physician: To tha best of my knowledga, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) within 2 e da 29b. Signatura and titla of certifiar

State Registrar

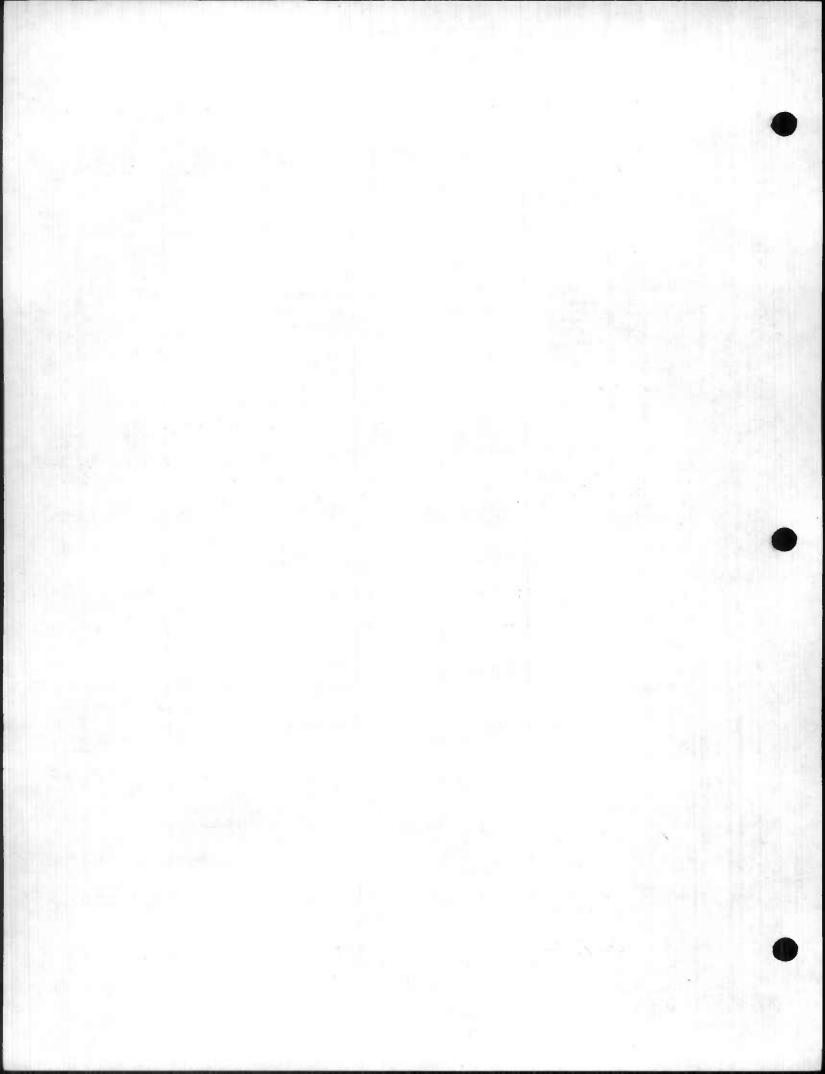
Robert

Vame

Thomas J. Enclow M.D. - St. Agnes HealthCare - 900 Caton Avenue Baltimore, MO

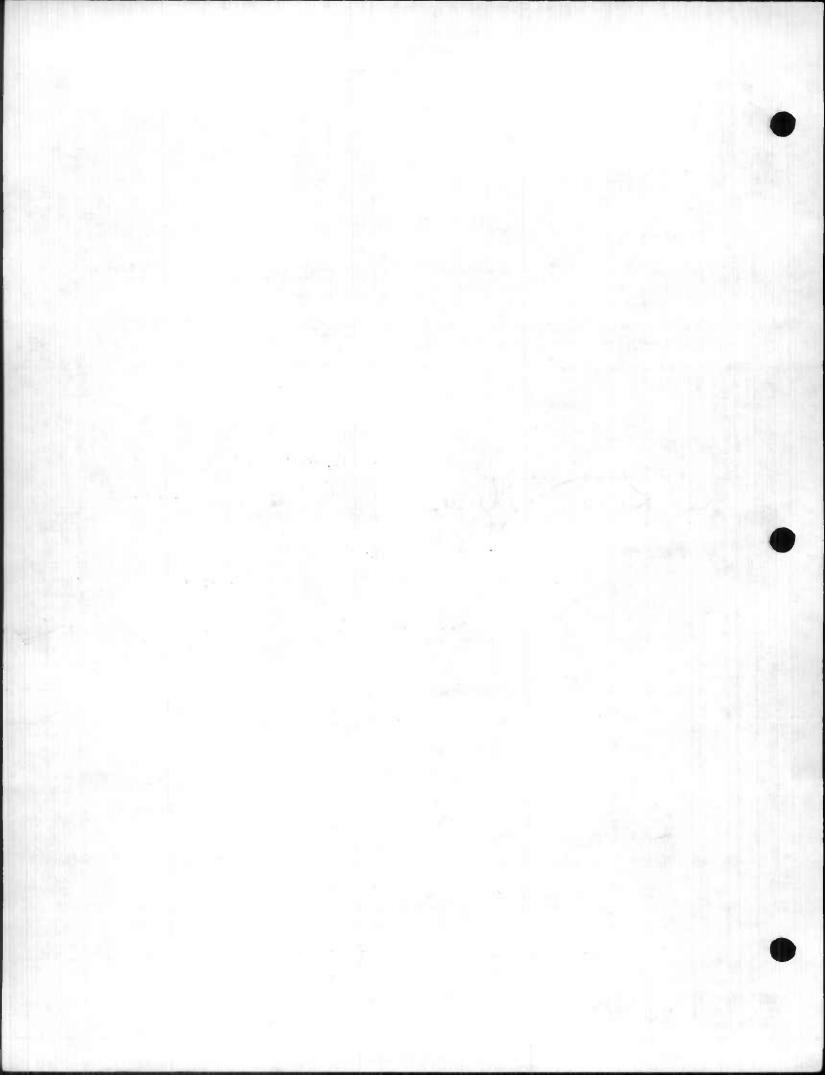
30. Nama end addrass of person who completed causa of daath (Item 23a) (Type, Print)

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 9 5 4 9

sician				Certific	ale of	Death		Reg	. No.	0.	9049		
sician	1. Decedent's Neme (First, Middle, L	ast)						Dete of Deeth Month	Dey	Year	3. Time of Dea		
edical	Samuel J	arman Wand	dless						8 200		3:47E		
miner	4a Facility Neme (If not institution, g				- 4		wn, or Location	n of Death	4c. County	of Death			
		Hospital					nberla			Legan	У		
al or	5. Social Security Number 8. 212-38-7461 Usual Residence of Decedent	Sex 1 M 2 F 7. Age	(In yrs. last birt	Mont	hs Days	Hours Hours	Min. Ju	Dete of Birth Month, Day, Y Ly 13, 1	(939	9. Birthple Countr VA	ce (Stete or Fo		
	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location									100	d. Inside City Li		
Director	MD Allegany Flintstone 10e. Street and Number 10f. Zip Code							1 □ Yes 2 🔀					
	Rt.2 Box 58	21530						10g. Citizen of What Country? USA					
by Funeral	11. Meritei Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces?	1 ☐ Yes 2 No			Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici □ Yes 2 No Specify:				e - American kk, White, et	c.		
etec	15. Decedent's I (Specify only highest g		16a.	Decedent's Usual Occupation (Give kind of work done during most of work			t of working	16	b. Kind of Bu	siness/Indu	stry		
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)	life. DO NO	T use retired	1)		D	Doggart				
5	9		G	coundsl	keeper		4 44 400		esort				
Be	17. Father's Neme (First, Middle, Las	51)						st, Middle, Ma	iden Sumam	10)			
2	Fred Wandless							Mae Kale					
	19e. Informent's Neme/Reletionship							Rural Route Number, City or Town, Stele, Zip Code)					
	Samuel J. Wandless	s,Jr./Son	Rt.			Berke	-	rings,			0		
	20e. Method of Disposition 1 Disposition 3	☐Removel from State	cemeter,	y, cremetory	or other place	ce)	D	ete 20	c. Location -	City of Tow	n, Siste		
	4 Donetion 5 Other (Spec	eify)				rkeley	Spri	ngs,WV					
	4 Donetion 5 Other (Specify) Mahnes Chapel Cemetery 3/21/2000 Berkeley 21. Signature of uneral Service Licensee 22. Name and Address of Facility Grove Funeral Home, P.A.												
	141 W. Main Street Hancock MD 21750-0368												
	23a. Pert1. Enter the diseese, or conshock, or heart feiture. List onl	mplications and caused to	ig, such as	cardiec or res	piratory arrest	l,		Approximate ntervel Between					
	or only of moon, round of blot of the	, circ second occir min									Onset end Deet		
	Immediate Cause (Finei disease or condition	Cardiac arrythemia							Date and 191		hr		
	resulting in deeth)									. 111.			
	Chromic cogestive heart failure yrs										yrs		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initialed events resulting in death) Last	. Нуре	rtensi ue to (or as e c	ve ca	rdio	vasc	ular :	heart	dise	ase	yrs		
1	Part II. Other algorificant conditions		23b. Did tobacco use contribute to the cause of death										
l	Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. C.O.P.D.										1		
									autopsy	avai	e autopsy findir lable prior to pletion of cause		
				A sell	9.	-6.		24e. Was en a performe	id?	of de	eath?		
1						-6.		24e. Was en a performe	. 1	of de	yes 2□ No		
in manaduna	25. Was case referred to medicai					26 Place	of Deeth (C)	performe	2 2 No	of de			
for manufacture and a	examiner?	Hospitel:	VIER/Out	instiant 3	DOA Oth	oc		performe 1 Yes	2 No	of de			
		28a. Dete of Injury (Month, Day			28c. Injur	er: 4 Nu	rsing Home	performe	2 No ca 6 □Oth	of de			
to be completed by	exagniner? Yes 2 No 27. Meryner of Death Death Death Death	28a. Dete of Injury (Month, Day)	Year) 28b. T	ime of ijury M	28c. Injur Wor 1	er: 4□ Nu y at k?	rsing Home 28d. No	1 Yes 1 Yes neck only one) 5 Residence Describe how	2 No ca 6 □Oth- injury occurr	of de			
Certification: To Be Completed by	exeminer Yes 2 No 27. Menner of Death Naturel 2 Accident 3 Suicide 4 Homicide 29a. Cerifier (Check only) 1 Certifying P 1 Certifying P	28a. Dete of Injury (Month, Day) on be 28e. Plece of Injury building, etc. hystclan: To the basis of a miner: On the basis of a	y - At home, fer (Specify) my knowledge, examination and	me of jury M m, street, fec	28c. Injury Word 1 (1)	y at k? Yes 2	No 28f.	performe 1 Yes seck only one) 5 Residence Describe how Location (Stree City or Town, 3	22 No ca 6 □Oth- injury occurr et and Numb Stete)	er (Specify) red	Yes 2□ No		
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edical certification: To be completed by	exeminer Yes 2 No 27. Menner of Death	28a. Dete of Injury on be d 28e. Plece of Injury building, etc. Thysician: To the best of and manner stell	Year) 28b. T Ir	m, street, fec	28c. Injur Wor 1 — etory, office	y at k? Yes 2 I	No 281. No 281. It is a second of place, and of the occurred at	performe 1 Yes 1 Yes 5 Resident Describe how cocation (Stre- City or Town, 3	2 No ca 6 □Oth injury occurr et and Numb Stete) se(s) and ma a and placa, to	er (Specify) red er or Rurel anner as sta and due to t d (Month, D.	Yes 2 No Route Number, led he cause(s)		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#16a PER F.H. G781 3-24-2000 JAB 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Vear WARRINGTON 01:35 MYRTLE ELIZABETH 22 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAL HOSPITAL BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1□M 25 F 212-22-9373 Yrs. MARVLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No YARY LAND 10e Street and Number 10f. Zip Code log. Citizen of What Country? 3416 KOAD 21216 USA. 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
It Yes, Give
Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK 3 ⊠ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ementary/Secondary (0-12) College (1-4or 5+) 2 HGRADE HENRYTON STATE HOSP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GROSS NILLIAM ELIZABETH 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAM GROSS 104 CHERRY HILL ROAD BALTIHORE, MD. 21225
Date 20c. Location - City or Town, State NEIC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1) Burial 2 Cremation 3 Removat from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL 03-28-00 BALTIMORE, MARYLAND 22. Nome and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME

2140 N. FULTON AVE., BALTINORE, MD. 2121; 21. Signature of Funeral Service Licensee D. FULTON AVE. BALTINORE, MD. 2/2/
I dying, such as cardiac or respiratory errest,

Intervel Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final Terminal assivation disease or condition resulting in death) Myocardial interction Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Kerral tailure Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3₽Probably 4□Unknown 1 Yea 2 No CVA 24b. Were autopsy findings evailable prior to completion of cause of death? curonic brouchitis 24a. Wes an autopsy performed? RID, GI bleer 2 1 No 1 ☐ Yes 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitet: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

by

Be Completed

Funeral

Director

8

8

Warniston,

Maryland

altimore.

2 should be 1 and Mental F

Pages

nt of Health a : If Item 27 to

The law requires that the death certificate be executed Box 68760, the 080 P.O. ate has been signed by page 2 should be detect Records, certificate of Vital Division

Physician/Medicai à Be Completed Medical Certification: To

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director; the funeral director direct

State

31. Date filed (Month, Day, Year)
MAR 2 4 2000

1 DNatural

2 Accident

3 Suicide

29b. Signature and

29a. Certifier

4 ☐ Homicide

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

32. Registrar's Signe

5 Pending investigation

6 Could not be determined

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number REG 000

1 Yes 2 No

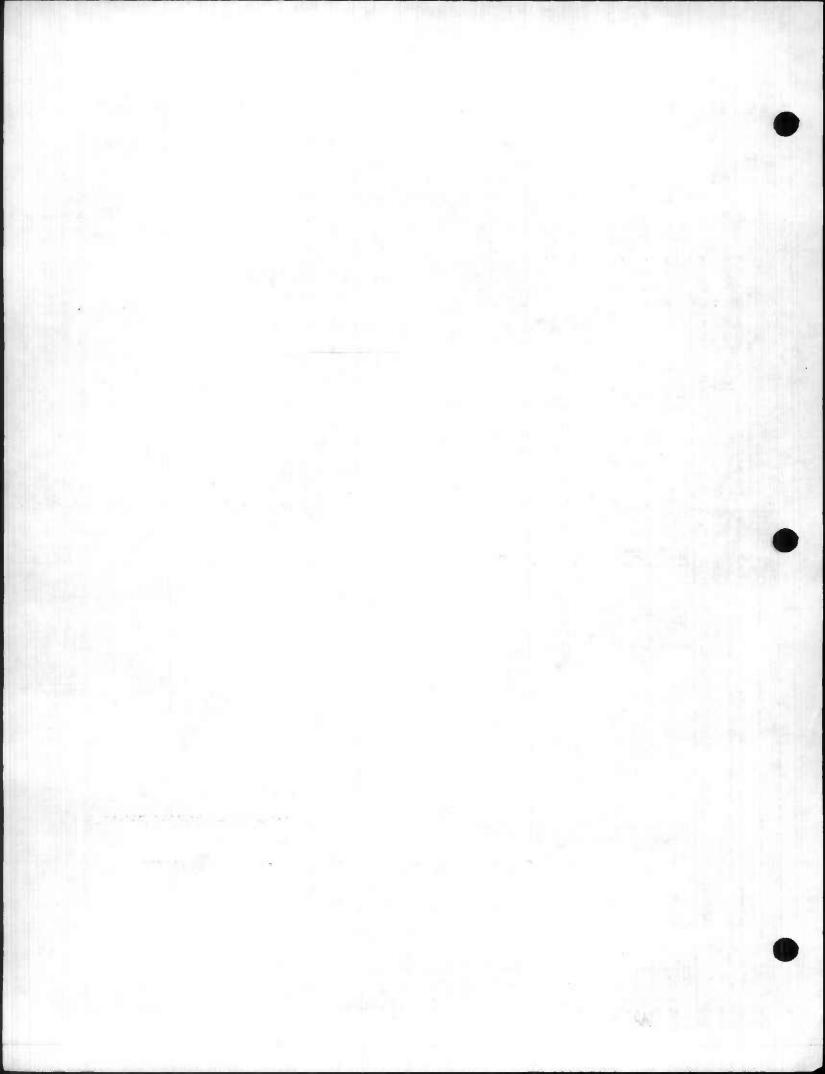
29d, Date signed (Month, Dey, Year) Marcu 22,2000

281. Location (Street and Number or Rurel Route Number, City or Town, State)

cause of death (Item 23a) (Type, Print) Baltimore, NO Belvedere

112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

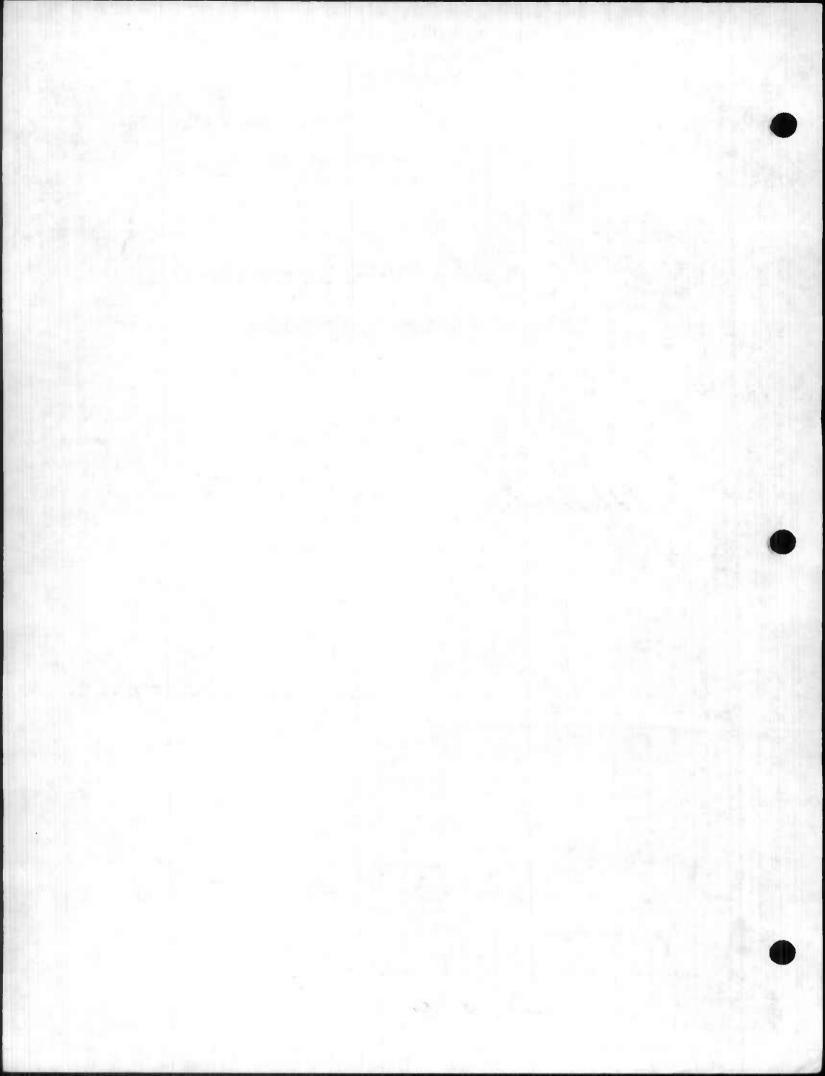


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Sally Wozny MARCH 20 2000 12:45A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CAMP SPRINGS MALCOLM GROW MEDICAL CENTER PRINCE GEORGE'S 7. Age (In yrs. last birthday) 82 Yrs. If Under 1 Yaar 5. Social Security Number 160 12 9806 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 F Director Sept 3, PA Usual Residence of Decedent death with the Meryland 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits 1 Yes 2 Tho P.G. District Heights Director 284-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 the Medical Examiner must be 23a 1905 Harwood Road 20747 Funeral United States 12, Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. or items 11. Marital Status filed within 72 hours after 1 Yas 2 No 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 No þ Specify.White 3₩idowed 4 Divorced Year or Dates: 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 6 Homemaker Home other Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mentai Pages 1 and 2 should be marked Stanley Zimny Frank Frances Krawczyk end ! 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health : If Item 27 is Eileen Sleight (DAUGHTER) 6007 Basingstoke Court, Centreville, VA 20120 20b. Place of Disposition (Name of cematary, cramatory or other place)

March 23qate 200020c. Location - City or Town, State 20a. Method of Disposition 8 1 Burial 2 □ Cremation 3 □ Removal from State Department of important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Nama and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signatura of Funaria Se A exandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final a INTRACEREBRAL BLEED disease or condition resulting in deeth) 24 HOURS Examiner Due to (or es a consequenca of) Examiner b. ARTERIAL HYPERTENSION The law requires that the death certificate be asscuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Dua to (or as a consequence of) USB 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contributs to the causs of death? detached 1 Yss 2 No 3 Probably 4 Unknown 2 of Vital Records, Be Completed by 2 24b. Were autopsy findings 24a. Was an autopsy performed? available prior completion of cause of deeth? page 2 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physicien: 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To this funeral 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation 1 Netural Injury s after death. 1 Yes 2 No 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature p 29c. License number 29d. Date signed (Month, Day, Year) UNQZ MD-D0036213 20 MARCH 2000 is of person who completed cause of death (Item 23a) (Type, Print) $89~\mathrm{MDG}/1050~\mathrm{W}$ PERIMETER RD ANDREW AIR FORCE BASE, MD 20762-6600 GUTIERREZ COL USAE, MC 31. Date filed (Month, Day, Year) 32 Registral WAR 2 4 2000 Registrar

DHMH 16 Rsv 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22, 2000 Cashmir Alfred Yankowski March 3:10 am 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 15 Propeller Drive Middle River Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) Months 1⊠M 2□ F 209 16 3291 April 29,1927 Pennsylvania Usual Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Middle River 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Propeller Drive 21220 USA 11 Maritai Status 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Reca - American Indian Black, White, etc. 1 Nes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married WW 1 Yes 2 No Specify: II specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Fire Fighter Baltimore, City 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles Yankowski Valera Kashen 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Marie Mowery (Daughter) 3337 Edwards Lane Baltimore, Md. 21220 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removel from Stete Holly Hill Mem. Gardens 3/25/2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 21. Signature of Funeral Service Licenses Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediete Cause (Finel CHRONIC OBSTRUCTIVE PULMONARY DISCASE disease or condition resulting in deeth) Due to (or as a consequence of) Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown ATHEROSCIEROFIC CARDIOVASCURAR 24a. Was an autopsy performed?

Physician /Medical Examiner

the

The law requires that the death certificate be axecuted

Box 68760,

P.O.

Division of Vitai Records,

or Attending Physician:

After this certificate hes

n 24 hours after death.

P Euneral Director: Aft pletely filled in by the fur

within 2 To the

funeral

completely

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

ment be notified at

Herra:

6

I Hyglene.

Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic avent

Department of Important: If any Injury or

Director

Funeral

à

Completed

the Maryland

death with

filed within 72 hours after

Baitimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

24b. Were autopsy lindings aveilable prior to completion of cause of death? Cerebrovoscular accident tilation 1 Yes 2 No 1 Yas 2 No 25. Wes case referred to medical examiner? 26. Placa of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27 Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNetural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, Iem, street, lectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

NACEM

32. Registrar's Signeture MAR 2 4 2000

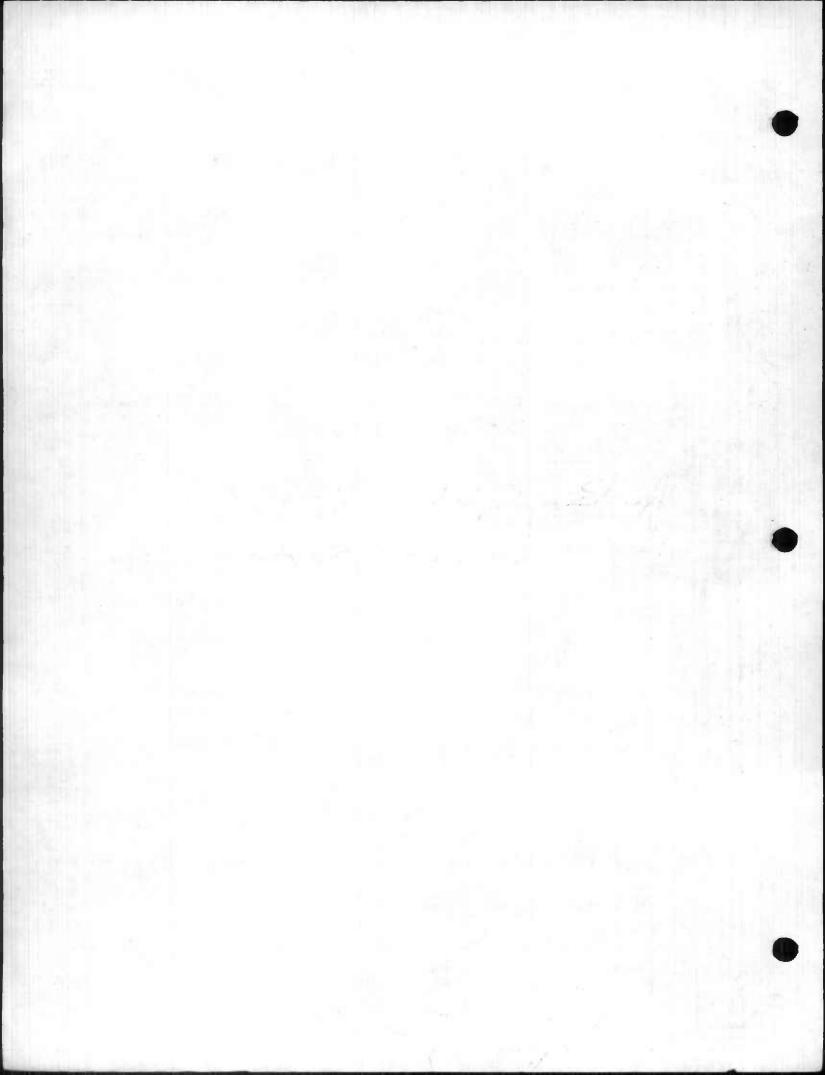
ESSEX

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

GAUHAR

Baltarone MD MED. CTR.

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 00 09553

	Certifica	ate of Death	Reg. I		2000					
Physician	Decedent's Name (First, Middle, Last)		2. Date of Deeth Month	Day Year	3. Tima of Death					
/Medical	Atanacio L. Acostar		March 2,	2000	12:30 PM					
Examiner	4a Facility Nama (If not Institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or L. Annapolis		4c. County of Death Anne Aru	ndel					
Funeral Director	5. Social Securify Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) From Month Usuel Residence of Decedent	Ser 1 Year I If Under 24 Hrs. S Deys Hours Min.	8. Date of Birth (Month, Day, Yea Aug. 14,	ar) Cour	9. Birthplace (State or Fo					
Now W	10a. Stete 10b. County 10c. City, Town or Location			1	0d. Inside City Lin					
28a-f ahow noutrast at	Maryland Anne Arundel Annapolis				1 □ Yes Z					
23a or	10e. Street and Number 1215 Tyler Avenue	21403		10g. Citizen of What Country? USA						
or its	1 Never Married 2 Married 1 Yes 2 No 1946	edent of Hispenic Origin? (Specify Cuben, Mexican, Puerto	ecity Yes or No- Rican, etc.)	Black, White,	4. Rece - American Indian, Black, White, etc. Specify: White					
or when 72 hours sheet by then "natural", or he t, the Medical Examina Completed by Fu	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of v	vork done during most of work	ing 16b	. Kind of Business/Inc	dustry					
than the Man	Elementary/Secondary (0-12) College (1-4or 5+) The DO NOT Chef	use retired)	Of	ficers Club	IISNA					
tal Hygiena. d other than event, the M	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maio							
Mental Mental arked of To B	Basilio Acostar	Maria La	brador							
la marked of summitteeve		ess (Street and Number or Rui			Code)					
Health em 27 I		phen Reid Rd. Hu								
nent of int: If It iry or o	20a. Method of Disposition 20b. Place of Disposition (A camefery, crematory of the disposition of the dis	rotherplace) terans Cemetery		Counsville, N						
Department Important: any Injury o	21. Signature of Funeral Service Licensee 22. Name		ylor Funeral Home, Inc. Annapolis, Md. 21401							
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.				Approximate interval Between					
hysician				Onset and Deat						
/Medical Examiner	Immediate Causa (Final disease or condition resulting in death) a. Septic Shock									
	Due to (or as a consequence of				24 hoi					
is-transit	b. Neumonia				Iwe					
ng physicia as the bur Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenfs resulting in death) Last Due to (or as a consequence of the cause of the consequence of the cause of the cau									
attendii I for use Ician/	Part II. Other stanklings and litera contribution to death but not continue to the underlying to the	s seven sives in Part I	23h Did tohac	co use contribute to	the cause of d					
ed by the attend of detached for us.	Part If. Other algnificant conditions contributing to death but not resulting in the underlying Renal Failure	g ceuse given in Pan I.	1 Yes		1					
cate has been signed by the attending age 2 should be detached for us. Completed by Physician/			24a. Was an au performed	17 av	era autopsy findii ailable prior to impletion of causi death?					
s certificate has director, page 2			1 ☐ Yes	2 No 1	Yes 2□ No					
ertific sctor,	25. Was cese referred to medicei examiner?	_0.00	th (Check only one)							
fer this certific uneral director. on: To Be	1 Yes 2 Wospital: Inpatient 2 ER/Outpalient 3 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 10 10 10 10 10 10 10 1	28c. Injury at Work?	ome 5 Residence 28d. Describe how in		(y)					
which 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	Accident 3 Suicide 4 Homicide Accident 5 Could not be determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)									
n 24 hours ne Funeral pletely filled edical C	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation)	ed at the time, date and place, on, in my opinion, death occur	and due to the cause red at the time, date	e(s) and mannar as s and place, and due to	tated. the cause(s)					
within 2 To the comple		29c. License nu <i>m</i> ber DH 35 494	29d.	Date signed (Month, 3/2/20						
	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) STEVEN RESNICK AAMC	64 FRANKI	LIN St.							
State	31. Date filed (Month, Day, Year) 32. Registrer's Signature	1	/- 51-	11000	, acr					
Registrar	MAD 03 2000 Severe B. A.	sa No								

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician FEB.25 2000 12:45 am GLADYS S. ANDERSON /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL GENESIS ELDER CARE SPA CREEK ANNAPOLIS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sax Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2対 F Yrs. **Director** 212-16-6954 1912 APRIL MARYLAND Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or liens 23s or 25s-f show dical Examiner must be notified at 1□ Yes 2□ No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 22 WASHINGTON DRIVE 21401 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried Maryland 21215-0020 Specify: BLACK 1 Yes 2 No Specify: 3 3 Widowed Wivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) US NAVAL ACADEMY LAUNDRY WORKER 7th permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: If hem 27 is marked other any Injury or other te-17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCES JOHNSON 2 ANDREW JOHNSON 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 SOUTHERN HILLS DR. ARNOLD, MD. 21012 FRANCES HEATH (GRANDAUGHTER) altimore. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition

2 Cremation 3 Removel from State Date 20c. Location - City or Town, Stata ANNAPOLIS MEM. GARDENS 3/1/00 ANNAPOLIS, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. Reese 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final MULTIPLE GRUAN PAINTE diseese or condition resulting in death) Examiner physician and s the burial-transit be executed Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Diseese or injury that Initialed events resulting in death) Lest Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably Unknown GANGHLENE signed b Records, b 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? JBITUS (INFECTOD Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case reterred to medical axaminer?

1 Yes 2000 8 26. Place of Death (Check only one) Hospitel: Other: Sursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending 1 Yes 2 No 2 Accident investigetion 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stelled. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) RIPGELY AV ANNOF Stephen C. Homi you, MO 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State MAR 0 2 2000 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Tarra S. Allen March 2, 2000 12:38am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Deeth Examiner P.G. County Hospital Cheverly Prince George's If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min Yrs. 579-66-8695 50 Jan. 14, 1950 Washington, D.C. Director Usual Residence of Decadent with the Manyland permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic avent, the Model Examples to other profit at any Injury or other traumatic avent, the Model Examples to other profit at any Injury or other traumatic avent, the Model Examples to other profit at a page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3453 23rd. Street S.E. 20020 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amaricen Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Marriad 2 Married 1 Yas 2 No Specity: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grads completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator Assistant 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Hezikiah Speaks Williford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Atiya Barbee/ Daughter 624 Suffolk Ave. Capitol Heights, Md. 20743 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata Harmony Memorial Park 3/8/00 4 ☐ Donation 5 ☐ Other (Specify) Landover, Md. 22. Nama and Address of Facility 21. Signature of Funeral Service License Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 11085 20747 23a. Part 1. Shear the discuss, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medical SEPSIS SYN DROME Hours **Examiner** Examiner Months CARCINOMO attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical thet initiated events resulting in death) Last Due to (or as a consequenca of): signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by been signated 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of causa of death? certificata has b lirector, page 2 s 1 ☐ Yas 20 No or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Depatient 2 ER/Outpatient 3 DOA 10 After this of funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 27. Manner of Death 28c. Injury et Work? Certification: 1 Matural 2 Accident 5 Pending Invastigation s after death.

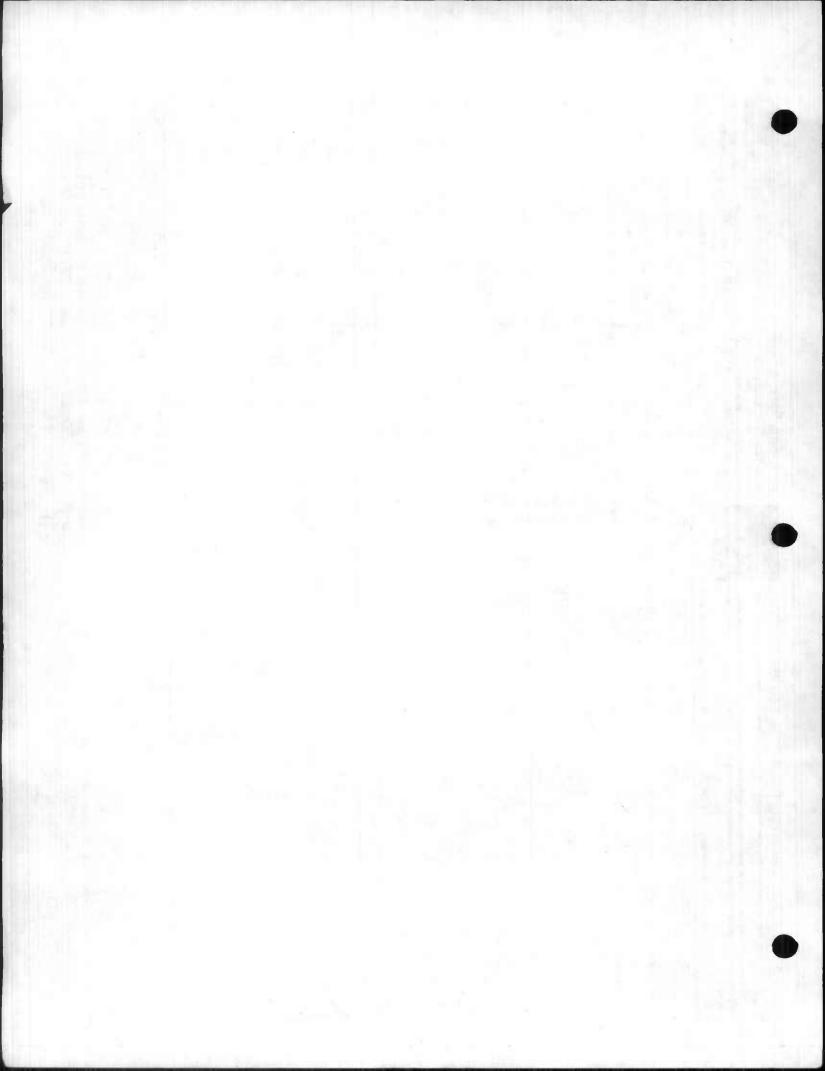
I Director: After the further of th 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after
 Funeral Dire
letely filled in b Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai completely (Check only one) within 2 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signature and title of certifie 2000 00052865 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) K. Michael Figaro, M.D. 7202 Quisinberry Way Bowie, Md. 31. Date filed (Month, Day, Year) Registrar's Signature MAR 0 8 2000 Registrar

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 28, 2000 **Physician** 7:55 PM Feb. Lillian Gertrude /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Center; Genesis ElderCare Salisbury, Md. If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ₩ F Yrs. 82 Director 214-10-6453 January 18,1918 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits fam 27 is marked other then "natural", or frams 23s or 28s-f show other traumstic avant, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Homewood Dr 21851 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hybjene. Important: If flam 27 is marked other than "natural; or flas any injury or other traumetic avant, the feature flasme 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 X Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White Specify 3 Wildowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Clerk Grocery 17. Father'e Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Benjamin W. Turner Lillie Hayes Baker 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel L. Adkins/Husband 600 Homewood Dr., Pocomoke City, MD 21851 20b. Place of Disposition (Name of cametery, crematory or other place) 20e Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 3/3/00 Parsonsburg, MD 4 ☐ Donetion 5 ☐ Other (Specify) Forest Grove Cemetery 21. Signature of Furural Service Licensee 22. Name and Address of Fecility Holloway Funeral Home Professional Association art1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, hock, or heart feiture. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 **Physician** METASTATIC Colon CANCER Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequenca of): 68760 Due to (or es e consequence of): Box P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? MERAPLASIA 2 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? waspital or Attanding Physician: The hin 24 hours after death.

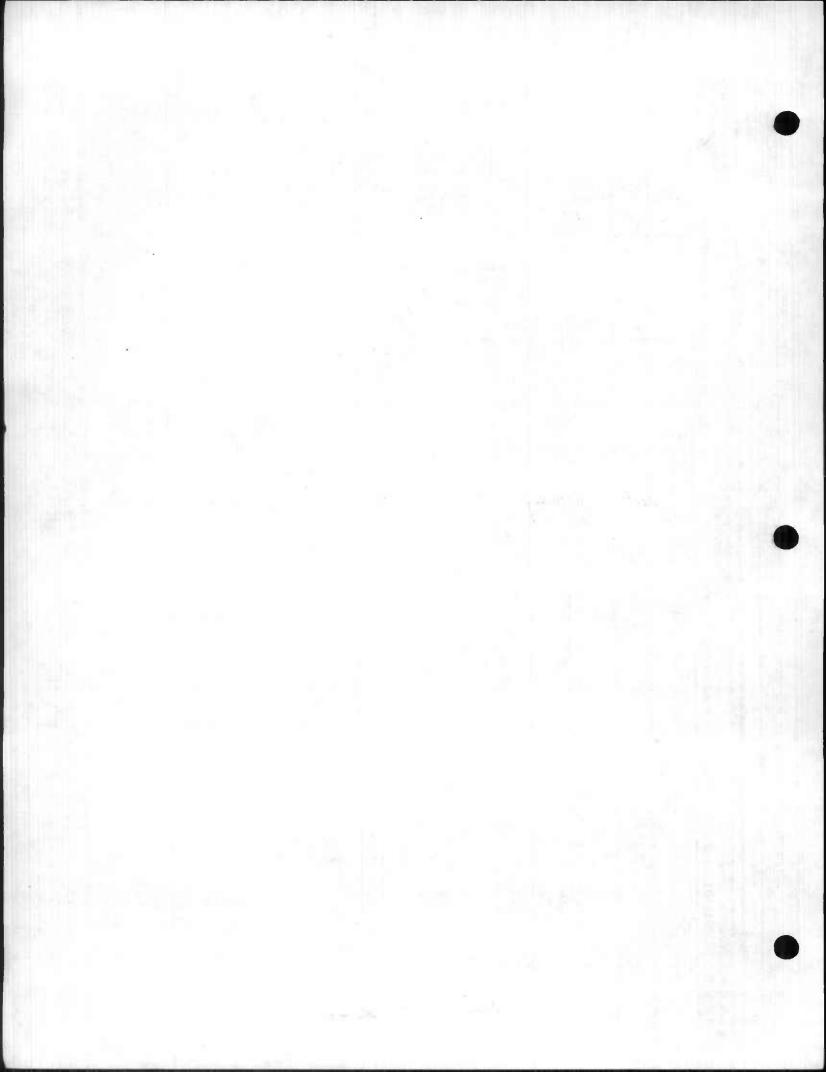
The Funeral Director: After this new lastey filled in by the file. 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide 1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) To the Within 2 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 5 1104 HEALTHWAY DR., SALISBURY, Md. 21804 32. Registrers Signeture State 3 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 09557. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician ALVIN VERNON 22, 2000 ACREE FEB. 1:30 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY CENTER; GENESIS ELDERCARE SALISBURY, MD WICOMICO If Under 1 Year 8. Date of Birth (Month, Day, Year) June 3, 1915 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Months Country) Maryland 10 M 20 F Yrs. 212-07-5453 84 Director Usual Residence of Decedent with the Maryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico Salisbury 1 Yes 2 No Directo 23s or 28s-f 10e. Street and Number 10f Zin Code 10a. Citizen of What Country? 717 Madison St 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Name 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 GYes 2 No WW II 18 No WW II 19 NO WW II 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Construction 12 aitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Department of Health and Mental Important: If Nem 27 is marked or any injury or other traumatic eventors. Alvin Vernon Acree Sr. Frances Chanev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Acree/Wife 717 Madison St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Wicomico Mamorial Park 2/25/00 Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Coenses 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 to use on each line. Approximate Interval 3atween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the turnest director, page 2 should be detached for use as the burle-transit completely filled in by the turnest director, page 2 should be detached for use as the burle-transit Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yss 2 No Division of Vital Records, Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 27. Manger of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Con the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29c. License number 29b. Signature and title of continu 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATKINS 6+IVA 1104 HEALTHWAY DR, SALISBURY, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 5 2000 Registrar



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year JOHN ALBERT ALTVATER March 6 2000 5:00 AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Genesis ElderCare

5. Social Security Number 6. Sex Easton If Under 24 Hrs. The Pines Talbot If Linder 1 Year 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M M 2□ F 61 212-38-8351 MAR. 30, 1938 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 20(No TALBOT TRAPPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30321 LLOYDS LANDING ROAD 21673 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 FARMER AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN VALENTINE ALTVATER NELLIE ELIZABETH PAHLMAN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ELAINE C. ALTVATER / WIFE 30321 LLOYDS LANDING ROAD, TRAPPE, MD 21673 20a. Method of Disposition 20b. Piece of Disposition (Name of cametery, crematory or other place) Dete 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LANDING NECK CEMETERY 3-8-00 TRAPPE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one ceuse on each line. Approximate Intervat Between Onset and Death tmmediete Ceuse (Finat disease or condition resulting in death) cerebror ascular accidents Weake Que to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): knosderosis, goveralited GERS

Physician /Medical Examiner

the death certificate be executed

Box 68760.

Records, P.O.

Division of Vital Attending Physician: death.

6 Hospital

To the Pwithin 2.

reportment of Health and Mental Important: If Nem 27 is marked on any injury or other

Pages 1 and 2 should be

Physician

/Medical

Examiner

Funeral

Director

show

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'natural', or home 23a

John Altvater Baltimore, Maryland 21215-0020

must be notified at

Director

Funeral

à

Completed

Be

MD

Examiner physician and the burial-tran 'sician/Medicai attending p for use as 980 signed t within 24 hours after death To the Funerel Director: A completely filled in by the f

	htributing to death but not resulting In the underlying cause given in Pert t.	23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknow			
		24e. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No			
25. Was case referred to medical	26. Place of Death (i	Check only one)			
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Oursing Home	5 Residence 6 Other (Specify)			
27. Manner of Death Naturai 5 Pending 2 Accident investigation		d. Describe how injury occurred			
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of trijury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

State Registrar

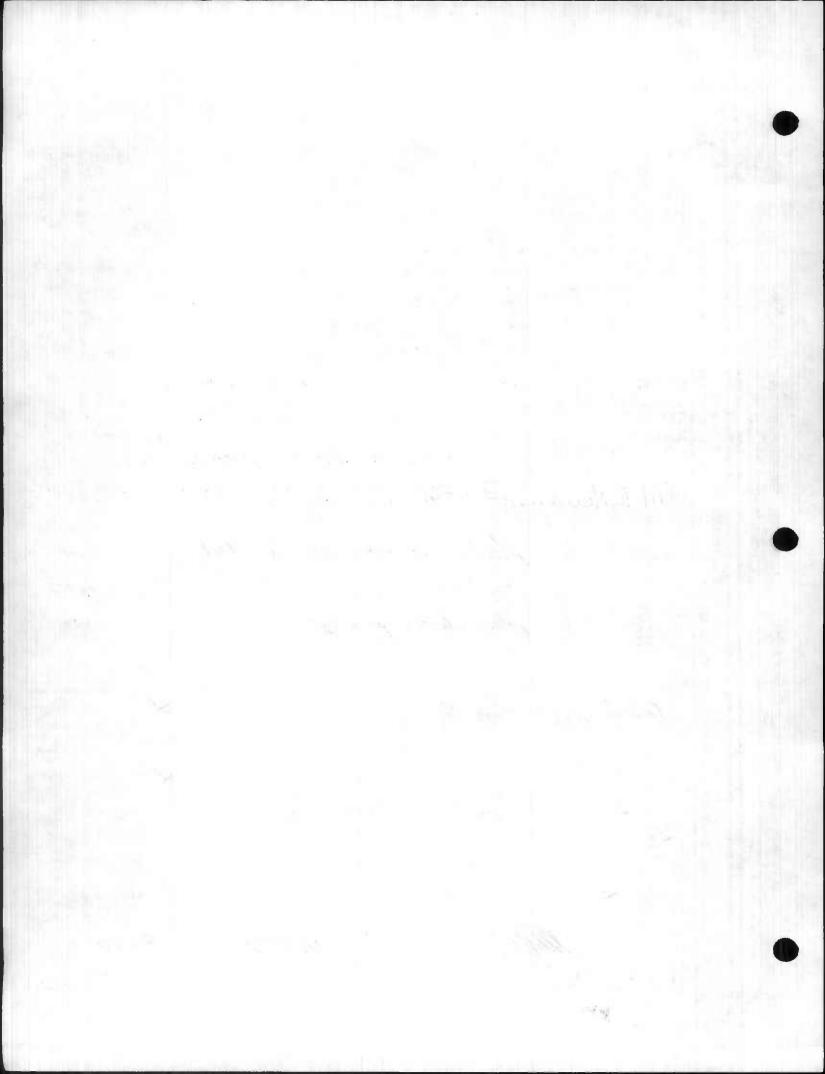
MD ROWLIEY 31. Date filed (Month, Dey, Year) 32. Registrer's Signature

29b. Signature and title of certified

30. Name and address of person who completed cause of deeth (trem 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) 3.6.00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 0 0 0

		1. Decedant's Name	a (First. Middla. La	rsf)			imouto o	f Death	2. Data of	Reg. No. Death		3. Time of Death	
Physician			leanor	E.	,	Andrew			Month March	Day	Yaar	2115	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Bruce H. Albert 2 2000 8:35PM March 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year)
Oct. 30,1955 If Under 1 Yeer | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Long Island, N. Y 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 17 M 2□ F Hours 212-72-4796 Yrs. Long Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g, Citizan of What Country? 413 Broadcreek Drive 20744 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Yes 27 No 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Home Improvement Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward G. Albert Joan K. Merriam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan K. Albert/Mother Same as item 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 3/5/2000 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
George P. Kalas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Kalas 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediata Causa (Final disease or condition resulting in death) Septicemia, Staphylococcus Aureus Due to (or as a consequenca of): Pneumonia, Staphylococcus Aureus Sequentially list conditions, if any, laading to immadiate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Altered Mental Staus Due to (or as a consequence of): Recurrent Gliobastoma Right Temporal Lobe 23b. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yas 2 No 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy YYes 2 No 1 Yas 20XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidence 8 Other (Specify) XXYes 2 No 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Investigation

Examiner Examine Records, P.O. Box 68760. Physician/Medical を þ Completed Be Certification: Division

Physician

/Medical

Examiner

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Funeral

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Funeral

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b Nerna 23a

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event.

Physician

/Medical

72 hours after

Baltimore, Maryland 21215-0020

1 X Natural 2 Accident 3 ☐ Suicide 4 Homiclde

29a. Certifiar (Check only

29b. Signature of

31. Dete filed (Month, Day, Year)

24 hours e Funeral Medical To the P within 2 To the P complet Registrar

to and address of person who completed cause of death (Item 23a) (Type, Print) /121 Congressional Lane #205 Rockville, Maryland Mario O. Belledonne

6 Could not be datamined

title of certifier

MAR 0 6 2000

32 Registrer's Signeture

and manner stated.

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

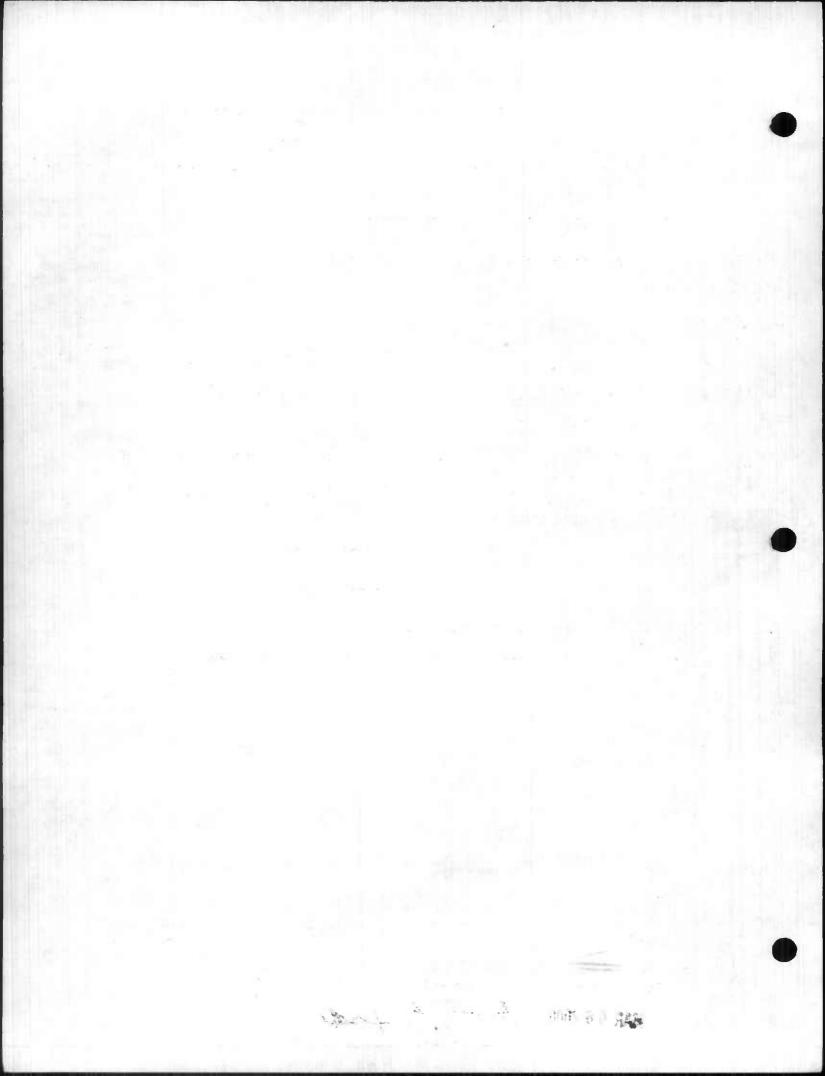
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s)

29c. License number D23177

281. Location (Street and Number or Rural Route Number, City or Town, Stata)

March 3, 2000

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND: #10b mcg 3/3/00 AACO HEALTH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HENRY H. BLAKE MARCH1 2000 1142 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner ANNAPOLIS

ar If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) MEDICAL ANNE ARUNDEL CENTER ANNE ARUNDEL If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) 6 Sax **Funeral** 11 M 20 F Months Days Yrs. 68 Director FEB. 1932 NEW JERSEY 140-26-3779 the Maryland r 28a-f ahow 10a State ANNE ARUNDEL 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 ☐ No Director MARYLAND ANNE ANNAPOLIS ANNAPOLIS 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8 234 1174 EASTPORT TERRACE 21403 US Funeral Hems 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 72 hours after 1 XYas 2 No
If Yes, Give
Year or Dates 952-54 1 Never Merried 2XX Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: BLACK P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry selfied within 7 all Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygie Important: if Itam 27 is marked other to any Injury or other treatments avent, this page. 18. Mother's Neme (First, Middle, Maiden Sum 8th CUSTODIAN MEDICAL CENTER 17. Father's Neme (First, Middle, Last) Be HARRY BLAKE HELEN CRAIG 19a. Informent'a Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 1174 EASTPORT TERRACE ANNAPOLIS, MD. 21403 BRENDA BLAKE (WIFE) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 3/7/00 CROWNSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) maryland veteran 21. Signature of Funeral Sarvice Licenses 22. Nama and Address of Facility wm. REESE & SONS MORTUARY, P.A. Laur Beese 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Physician/Medical Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) 68760 Due to (or as a consequence of): Box 188 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed The iaw 1 Yes 2 No 1 ☐ Yes 2 ☐ No of VItal 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 2E No 1□ Yea 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attanding 1 Naturel 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

State

Registrar

edical

29a, Certifier (Check only one)

29b. Signatura and title of certifiar

30. Name and address of person

31. Dete filed (Month, Day, Year) MAR 03

mD 5 32. Floquirar's Signature

no completed cause of death (ttem 23a) (Type, Print)

m.D.

600 Ridgely Aug Subtr 23/ Annapolis, and 2140/

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

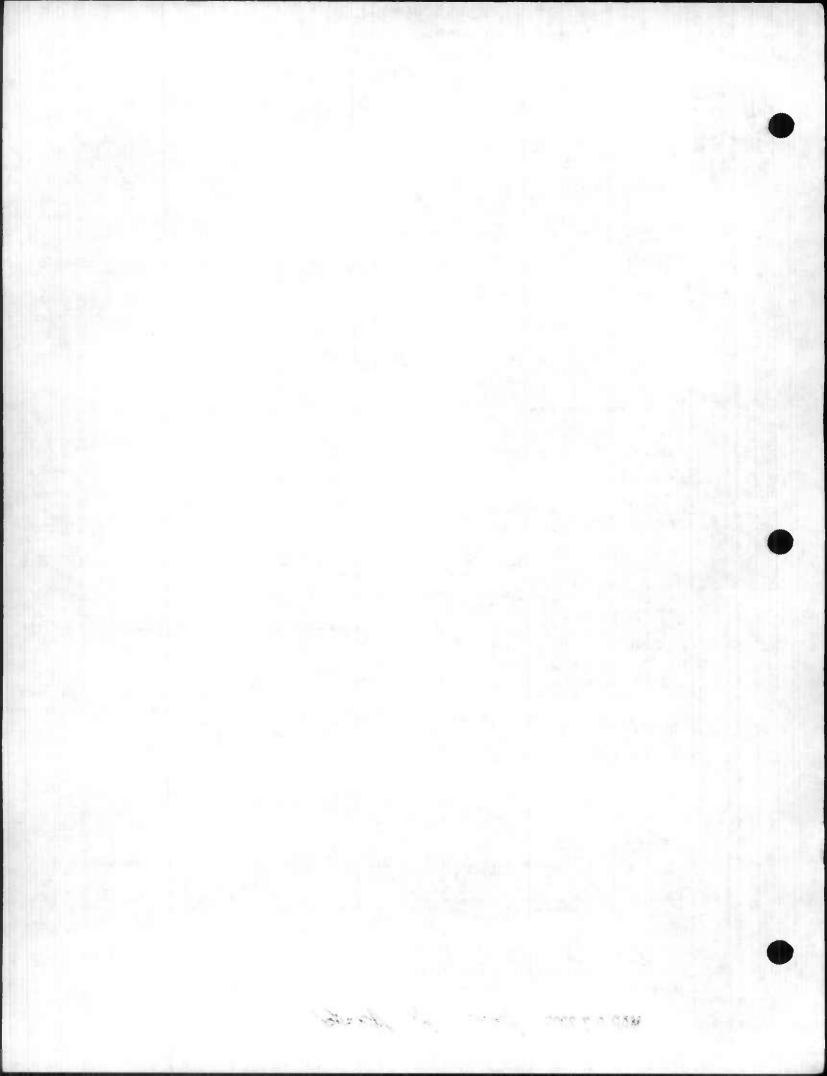
29d. Data signed (Month, Day, Year)

About the most offer to day

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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al	ULYSSES BRO				1	MARCH		1255				
er ^{4a}	Facility Neme (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County of De	eath				
	ANNE ARUNDEL M	EDICAL C	ENTER	ANNAPOI		ANNE AI	RUNDEL					
5. 5	Sociel Security Number 6. Sec		(In yrs. last birthda				h v. Year) 9. E	Birthplace (State or Foreig Country)				
	216-18-5308 2 F 75 Months Days Hours Min. (Month, Day, Year) Usuel Residence of Decedent											
108	a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit				
ò .		DIMIDET	ADMOTE					1 X Yes 2 □ N				
6 M	ARYLAND ANNE A B. Street and Number	RUNDEL	ARNOLD	10f. Zip Code			10g. Citizen of Whet	Country?				
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5 11.		12. Wes Decedent Ev Armed Forces?		If Yes, specify Co	f Hispenic Origin? (uban, Mexican, Pue	rto Rican, etc.)	Black, W					
	1 Never Married	1 X Yes 2 □ No If Yes, Give Yeer or Dates:	W.W.II	1□ Yes 20 N	o Specify:		Specify:	BLACK				
1	15. Decedent's Edu	cation	16a. Dec	cedent's Usual Occ	cupation		16b. Kind of Busines	ss/Industry				
Completed	(Specify only highest grade	e completed)	(Gir	ve kind of work don DO NOT use reti	ne during most of w	orking						
E	Elementary/Secondery (0-12)	College (1-4or 5+		MINICAE	D		AME COL	NFRENCE				
	Father's Name (First, Middle, Last)			MINISTE	-	ame (First, Middle,	Maiden Sumeme)	VERENCE				
ñ		OKC T										
0	ULYSSES BRO					OR SPRIC						
	a. Informant's Name/Relationship (Ty						or, City or Town, Stete					
L	ILLIE B. BROOK	S (WIFE)			ACRES RI	D. ARNO	LD, MD. 2					
208	a. Method of Disposition	Daniel 4 Otata	20b. Placa of Dis	position (Name of rematory or other p	olaca)	Date	20c. Location - City	or Town, Stete				
	1 ☑ Burlal 2 ☐ Cremation 3 ☐ F		MARYLA	ND VETE	RAN	3/9/00	CROWNSV	ILLE, MD.				
21			1			3/3/00	ORO MILO V	LLLD, III				
	21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility WM. REESE & SONS MORTUARY, P.A.											
	Larry S. Reese 821 WEST STREET ANNAPOLIS, MI											
23	 Part1. Enter the disease, or cemple shock, or heart failure. List only or 	icetions that caused to ne cause on each line	he deeth. Do not e	enter the mode of d	lying, such as cardi	ac or respiretory e	rest,	Approximate Interval Between				
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Im	Immediate Cause (Final disease or condition a ACUTE RENAL FATURE											
	sulting in deeth)		ue to (or es a cons					ONEDA				
Examiner			PRATI					ONEDAY				
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y if a	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events Due to (or as a consequence of): C. METASTATIC PANCREATIC CANCER Due to (or es e consequence of):											
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Ca tha res	sulting in death) Last	D										
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O De	t II. Other eignificent conditions con	ntributing to death but	not resulting in the	underlying cause		22h Did	tobacco use contrib					
10 10				underlying oddse	given in Part I.	230. DIG	-	ute to the cause of dea				
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Completed		MACT		EUMON	IIA	1 🗆	an autopsy med?	Probably 4 Unknown				
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To Be Completed by Phy:	Was case referred to medical exemine?		1 NFE	EUMON CTION	26. Place of D	24a. Was perfo	an autopsy 24 rmed? /es 2□No phe) dence 6 □Other (S	Deprobably 4 Unknown. b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No				
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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** WILLIS EDWARD BOOLE, JR. March 12, 2000 0745 am /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1529 Ocean Highway Pocomoke City Worcester If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday). 5. Social Security Number 213-05-2005 8. Date of Birth (Month, Dey, Birthplace (Stete or Foraign Country) **Funeral** Months M 2DF Days Hours Director Virginia 12/20/19 Usual Residence of Deceden death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be multified at 10d. Inside City Limits 1 ☐ Yes 2 No Worcester Pocomoke City Directo 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 1529 Ocean Highway 21851 USA Funeral 12. Wes Decedent Ever in U,S. Amped Forces? 1 2 Yes 2 □ No WW II If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Raca - American Indian, Black White, etc filed within 72 hours after 1 Never Married 2 Merried natural, or 1□ Yes 2 No Specify: White þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Retail 12 17. Fether's Name (First, Middle, Last) other permit. Peges 1 end 2 should be file Department of Heelth, end Mentel Hy Important: if fem 27 is marked oth any linjury or other traumatic event 2008. 18. Mother's Name (First, Middle, Meiden Surnama) Willis Edward Boole, Sr. Harriett Joynes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Evelyn Boole/ Wife 1529 Ocean Highway, Pocomoke City, MD 21851 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, State Salisbury Crematory 3/13/00 Salisbury, MD 22. Name and Address of Facility Holloway Melson Funeral Home, PA 21. Signeture of Faneral Service Licansee Michael Dean m01129 103 Linden Ave. Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARCINOMA Examiner Due to (or as a consequence of): GENERA Physician/Medical Examiner The law requires that the death certificate be executed ettending physician and for use as the burial-tran Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in deeth) Last Due to (or es e consequence of) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen ate hes b 2 N No 1 □ Yes 1 □ Ves 2 □ No certificate or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t Certification: 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No efter death. Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 2 24 hours efter Funeral Directors letely tilled in b 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) and manner as stated.

2 Medical Examinar: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and menner stated. 29a, Cartifie To the Hosp within 24 ho To the Fune completely ti (Check only 29c. License number 29b. Sign 29d. Dete signed (Month, Day, Year)

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

100 31. Date filed (Month, Day, Year) MAR 14 Registrar

8th.

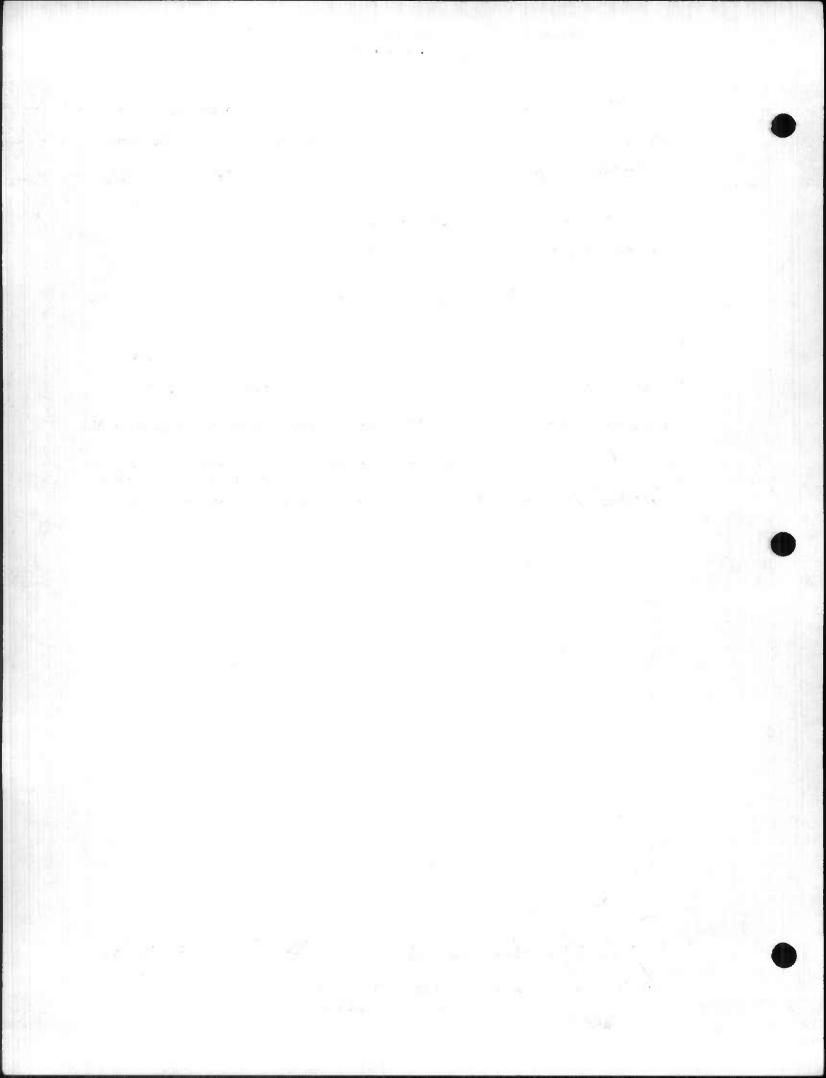
St.

Pocomoke City, 32. Registrer's Stonature

address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year Joseph Guthrie Black March 2000 11:35 PM 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Center Annapolis Anne Arundel If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sev 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Days XM 2□ F Months Hours 88 12/01/1911 405 05 3958 Kentucky Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 Yes 2000 Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Bestgate Road 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?

VEY'es 2 No 1942If Yes, Give Year or Dates: 1945 11. Meritei Stefus Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3.☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) 5+ Pharmacist Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) James Garfield Black Betty May Neely 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jeffrey Albert (nephew) 124 Bryans Channel Way, Queenstown MD 21658 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/3/00 Alexandria VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Services Melanuste 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate interval Between Onset and Death immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last mound 0 Pert ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? completion of ceuse of death? 10 1 Yes 2□ No 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) 1212 Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 8 Other (Specify) 3 DOA 28a. Date of injury (Month, Day Year) 28d. Describe how injuly occurred 28b. Time of 28c. injury at Work? Naturai
Accident 5 Pending

Physician /Medical Examiner burial-transit and physician Box 68760. the

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the Hospital or Attanding P hin 24 hours after death. the Funeral Director: After I

within 2 To the F

Records, P.O.

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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death

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Experient must be notified at

permit. Peges 1 end 2 should be filed within Department of Health and Mental hygiene. Important: If Item 27 is marked other than *!

Examiner Physician/Medical signed by t d be detact Completed by Be Certification: To

1 Yes 2 No Manner of Death

investigation

Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Severna

29a. Certifier (Check only one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Name and address of person who completed ceuse of death (item 23a) (Type, Print)

29c. License numbe

29d. Date signed (Month, Day, Year)

Location (Street end Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Dey, Year) State

edical

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Um 32. Registrer's Signeture

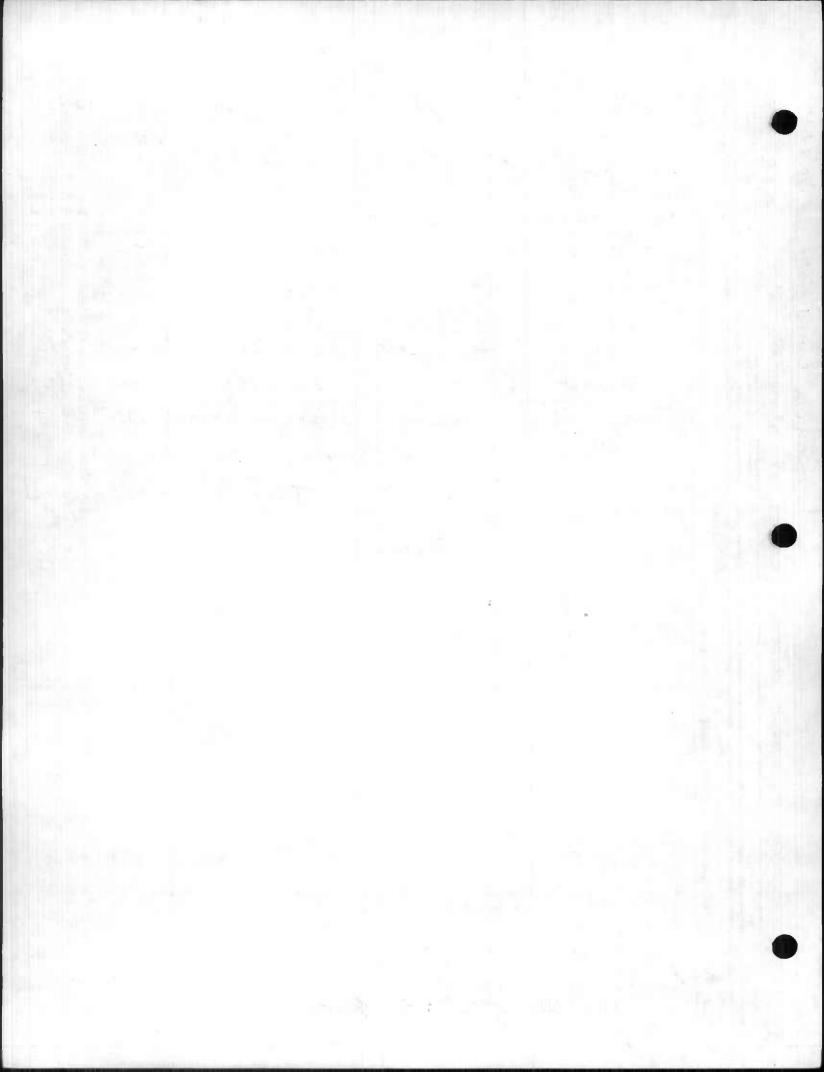
Registrar

2009 0 2 2009

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** SANGRA February 13, 2000 pation of Death 4c. County of Death 1242 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death **Examiner** 231-48-83 PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Z-Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 231-48-8321 1 M 2 T Director 16-Usuei Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 465 2 No ICO MICO 5 (MAR Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 or Berra 23a 205 KRST NUT USA 21875 Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Maritel Status ☐ Yes 2 Yes, Give 2 No 1 ☐ Never Merried 2 ☐ Merried Life Maryland 21215-0020 Specify: 1 Yes 2 No 3 ₩idowed 4 Divorced Year or Dates: Boyd Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 LOON CORAT ER ood 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) 88 CliAm 8 and Mental Abrith ANNIPE LANG Lo ZAKN EST 19b. Meiling Address (Sireet and Number or Rural Rocke Number, 19e. Informent's Neme/Relationship (Type, Print) City or Town, Stete, Zip Code) If Norm 27 is ChestNat 265 B)Austral RIMAC BRR 21875 NO Baltimore, 20b. Plece of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State cemetery, cr emetory or other plece) 1 Burlei 2 Deremetion 3 □Removei from State - CA MITTORE 4 ☐ Donation 5 ☐ Other (Specify) SOFEL 21. Signeture of Funerel Service Learning 22. Neme end Address of Fee ility ENNIFE Small SHISBARC Approximete Interval Between Onse and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel QU Im disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and Due to (or as e consequence of): Box 68760, The law requires that the death certificate be Physician/Medical eun Due to (or es a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 PNo Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To No Yes 2□ No 2 ER/Outpatient 3 DOA 1 Inpatient this 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After 1 Neturel 5 Pending investigation death. 1 Tyes 2 No 2 Accident Hospital or Attending 24 hours after death Funeral Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical completely (Check only one) within 2 \$ 29c. License number 29b. Signeture and title of cortified 29d. Date signed (Month, Day, Year) 45049 13/00 DME VO.0. 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Chr.'s topher Snyder 106 od (Month Dev. York) 2000 32. Registrer's Signature FEB 15 2000 106 MilFord St. Swite 201, Salisbury Md 21804 5

DHMH 16 Rev 6/95

State Registrar



Piease Type or Print in Black Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Dav Month Year **Physician** 0340 BEATRICE march LOUISE BURTON Zcan /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□ M 2XF 67 Yrs. 222-22-0674 Director NOV. 16, 1932 DELAWARE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director 28a-f MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? must be ŏ USA 14. Race - American Indian, 2901 MERRITT MILL ROAD 21804 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: P WHITE 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tile. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRY CLEANING OPERATOR DRY CLEANING 10 17. Father's Name (First, Middle, Last) 16. Mothar's Nama (First, Middla, Maidan Surname) Be Pages 1 and 2 should be naml of Health and Mental ORVILLE LATHBURY BEATRICE SULLIVAN 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) of Health a If hem 27 is or other tra PENNY B. MEADOWS/DAUGHTER 2901 MERRITT MILL ROAD, SALISBURY, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 DCremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 3/8/00 SALISBURY, MARYLAND 22. Name and Address of Facility Herris HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part : Entar the disease of plications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) 028240 A11 Examiner Due to (or as a consequence of): Physician/Medical Examiner Como physician and the burial-transit De lo lor as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dr 3/ Distamosaly Due to (or as a consequence of): 8 USB signed by the a Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 A ras 2 No 3 Probably 4 Unknown Presmonergon ρ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No director. 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1□ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation or Attending 1 Natural 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 26e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 2 4 ☐ Homicide filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year)

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

K oser 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Maryland

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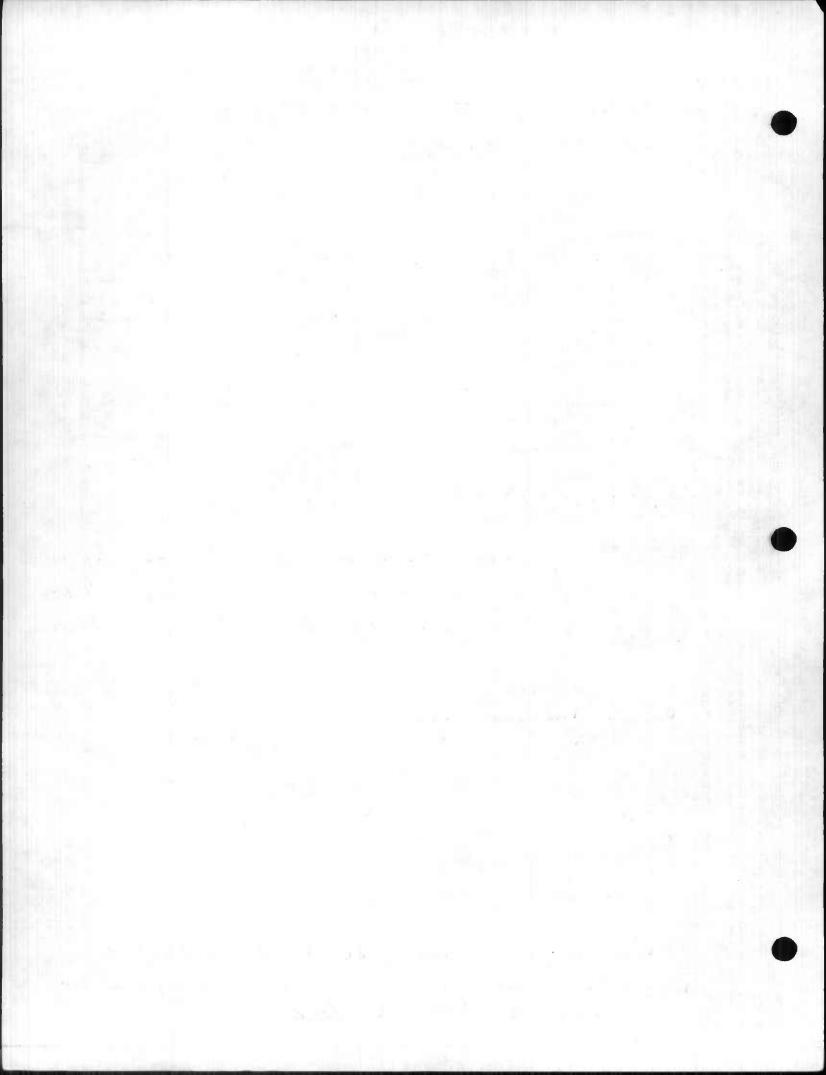
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32. Registrar's Signature



Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Tima of Death Dey Month Year **Physician** 0520 KEBRUARY 29, 2000 Τ. Blake, Jr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10M 20 F Director 212-56-1212 Feb. 9, 1933 Maryland Usual Residence of Deceden 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No 28a-f Directo Maryland Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? mart be n USA 103 N. Bay Street 21863 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Merried 2 Nerried b 1 ☐ Yes 2 ☒ No Specify: PV 3 ☐ Widowed 4 ☐ Divorced "nathural" Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. filed within Elementery/Secondary (0-12) College (1-4or 5+) Poultry Plant laborer Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be till ment of Health and Mental H lant; If them 27 is marked oilb lury or other traumatic even Perry Thomas Blake, Sr. Ruth Spencer 19e. Intormant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Bernice Blake/ wife 103 N. Bay Street - Snow Hill, Maryland 21863 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any injury or ance. Wesley Church Cemet, 3/04/00 Snow Hill, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD Jolley Memorial Chapel 21801 23a. Pert1. Enter the disease, or complication shock, or heart tellure. List only on the ions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Interval Between Onset and Deeth **Physician** Immediete Cause (Finel disaese or condition resulting in deeth) /Medical estates Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and 68760 acerl Due to (or as a consequence of) P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to completion of causa of deeth? Completed 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 WNo 1 ☐ Yes 2 ☐ No of Vital 25. Was casa referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation Division Attending 1 Seturel death. 1 Yes 2 No after death Director: 2 Accident the 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier (Check only one) 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, Md. 1104 William obins M.D 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Ray 6/95

Registrar

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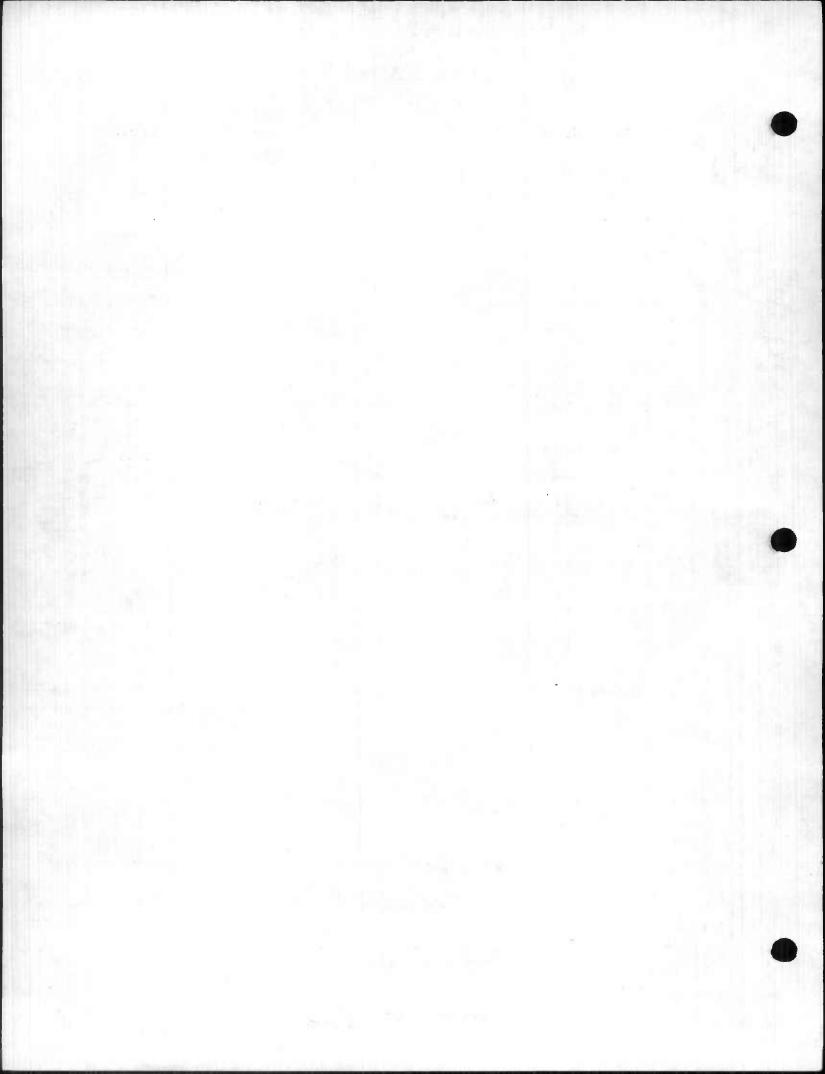
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8:30 PM NANCY FEB. 19 2000 LEE BOWDEN 4b, City, Town, or Location of Deeth 4c. County of Death 4e Facility Name (If not institution, give street and number) BERLIN WORCESTER ATLANTIC GENERAL HOSPITAL If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpleca (Stete or Foraign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6 Sax 1□ M 2\ F Months Days Yrs. 53 221-36-6306 NOV. 24, 1946 MARYLAND Usual Rasidence of Decedent 10d Inside City Limits 10s State 10h Counts 10c. City. Town or Location 1 ☐ Yes 2 No DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? RT. 2 BOX 52 19975 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ሺ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Orlgin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Maritai Status Bleck, White, etc. 1 Nevar Marriad 2 X Marriad 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) HATCHERY WORKER 12 POULTRY 18. Mother's Neme (First, Middla, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) NORMAN F. BUNTING NORMA LEE BLOXOM 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) HERBERT W. BOWDEN/HUSBAND RT. 2 BOX 52, SELBYVILLE, DELAWARE 19975 20b. Plece of Disposition (Neme of cemetery, crametory or other plece) Deta 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Steta 2/24/00 4 ☐ Donetion 5 ☐ Other (Specify) ROXANA CEMETERY ROXANA, DELAWARE 22. Nama end Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 and the deeth. Do not enter the moda of dying, such as cerdiac or respiratory arrast, each line. 23a. Pert1. Enter the disaase, or complications unit shock, or haert feilure. List only one ceurs and the Approximata Intarval Batween Onset end Death Immediate Cause (Finel disease or condition rasulting in daeth) Sequentially list conditions, if eny, teeding to immediate cause. Entar Underlying Ceuse (Diseese or injury that Initiated events rasulting in death) Last Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of causa of daath? 24e. Was en eutopsy

Physician /Medical Examiner

Physician

`Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or treumstic event, the Medical Examiner must be

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filed within 72 hours efter death

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Pages 1 and 2 should be filt ment of Health and Mental Hyant: If Item 27 is marked oth lury or other treumatic event

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Baltimore,

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/Medical

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Examine Physician/Medicai py Completed Be Certification: To

After this certificate has funeral director, page 2:

or Attending Physician:

31. Data filed (Month, Day, Year) FEB 2 3 2000 State

Medicai

1 Yes 2 1 M6 1 ☐ Yes 2 ☐ No 25. Was cesa rafarrad to medicel examiner?

1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. tnjury et Work? Nature 5 Panding investigation 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28e. Plece of injury - At home, farm, straet, factory, office building, etc. (Specify) 4 - Homicide

1 Certifying Physician: To tha best of my knowladga, daath occurred at the time, date and due to tha ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at tha time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier

(Check only one) 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signature and title of certifier

Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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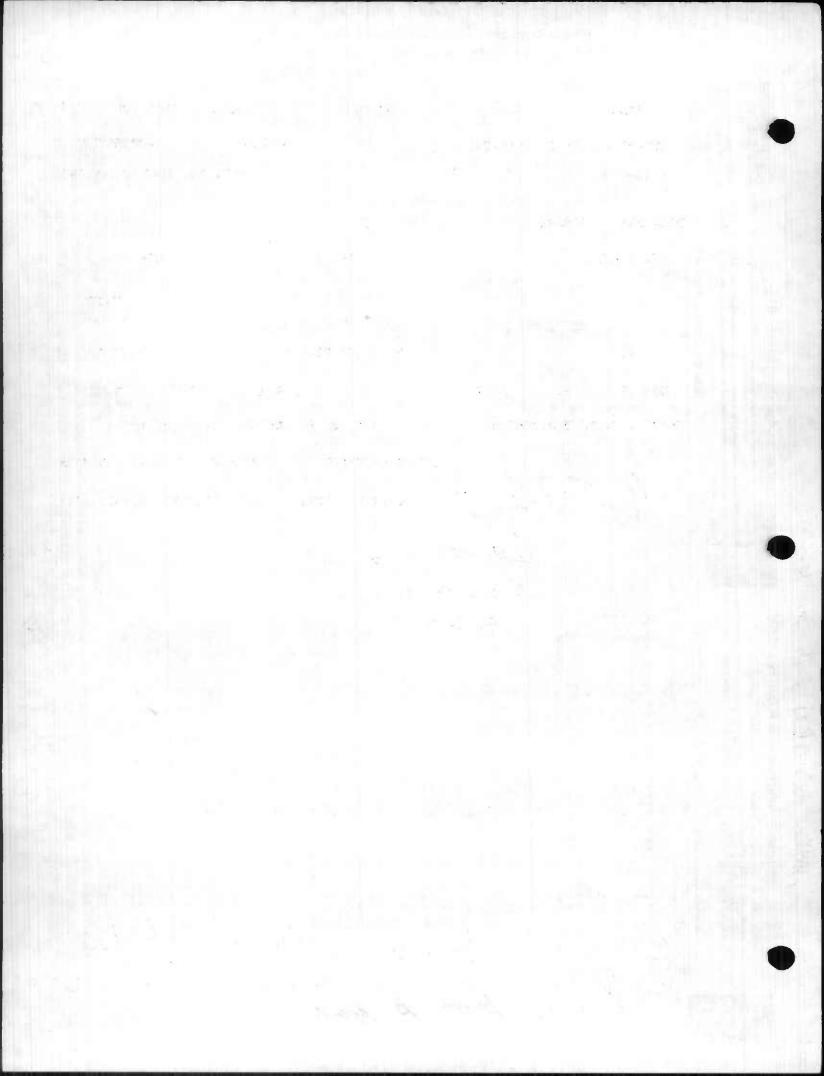
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DHMH 16 Rev 6/95

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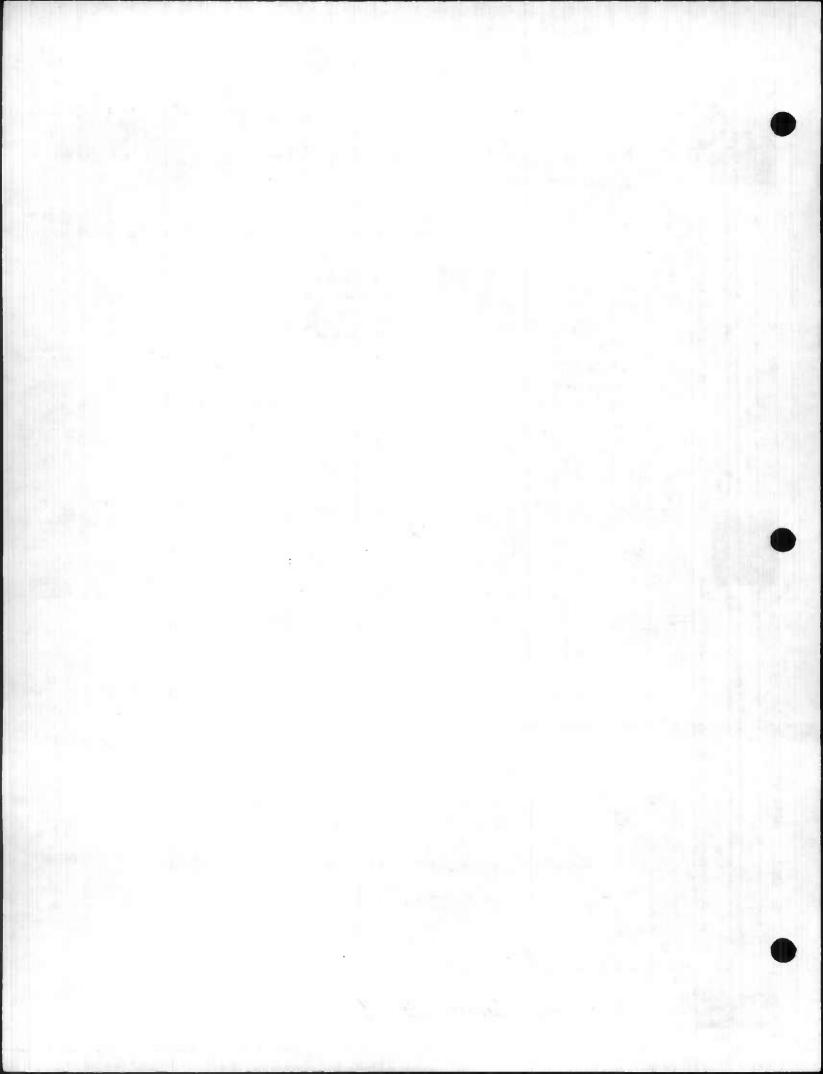


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State of Maryland / Department of Health and Mental Hygiene 0 9569

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17. Father's Name (First, Middle, Las	it)				18. Mother's Ne	me (First, Middle	, Maiden Suman	ne)	
CHARLES EDWARD	FLUHARTY				MARGARE	T ELIZA	BETH SCH	UTZ	
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J. KENNETH BARWI	CK/ HUSBAN	D 8	3748 BT.A	CK DO	G ALLEY.	EASTON	MD 216	01	
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page								Yes 2 No	1 ☐ Yes 20 No	
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er this neral di	27. Mennar of Death	28a. Data of I	-	Tima of Injury	28c. Injur Wor	y at	28d. Descr	ribe how injury occu	ırred	
r: Ath	1 Natural 5 Pendi 2 Accidant invasi	igation 2/26	, 100	M	10	Yes 27th	lo			
er de mecto by ti	3 Sulcide 6 Could 4 Homicide datan	nined 288. Place of	Injury - At homa, I , etc. (Specify)	arm, street, fact	lory, office		28f. Locati	on (Street and Num	nber or Rural Routa Number	
od in		ounding.	, oto. (opoorly)	Homi	E			Ston, m		
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifyi	ng Phyaician: To the be	est of my knowledg	e, death occurre	ed at tha tin	na, data and	place, and due lo	the cause(s) and n	nanner as stated.	
within 24 hours after death. To the Funeral Director: After completely filled in by the lune. Medical Certification:	one).	and manner	s or examinetion a r ataled.	nd/or invastigeti	ion, in my o	pinion, deatr	n occurred at the ti	me, date end place	, and due to the cause(s)	
To the	29b. Signatura and title of certifi	9 11	0		29c. Licens			29d. Data sign	ed (Month, Day, Year)	
	Vin	dut	7		100	557	125	3/10	160	
	30. Nama and addrass of persor	who completed cause of	of death (Item 23a)	(Type, Print)	100			ton mb		
	NUEL HUN	TE 60.								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Frederick J. Best 7, 2000 March 12:45 pm 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center Elkton Cecil If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1X M 2 F Yrs Virginia 82 Sept. 16, 1917 221-09-2117 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Biggs Hwy. 21911 USA Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WW II Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Computer Programmer Federal Government 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumame) Earl Best Elsie Spotswood 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Enis Best/Wife 404 Biggs Hwy., Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-10-00 Rising Sun, Maryland Ebenezer Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 ooghe 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Cause (Final disease or condition resulting in death) Due to (or as a consequence of): with Omyo Due to (ar as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

68760

Box

P.O.

Records,

Division of Vital Attending Physician:

The law requires that the death

physician and s the buriel-transit certificata be executed

use as

Sign

this Affer

To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu

death.

altimore, Maryland 21215-0020

Pages 1 and 2 should be and Mental is marked

Department of Health Important: If Item 27 I

Physician

/Medical

Examiner

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Funeral

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Completed

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Examiner

Physician/Medical

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Certification: To

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Funeral

Director

28a-f

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Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last

24a. Was an autopsy

2 50 No

24b. Were autopsy findings available prior to completion of cause of death?

1 T Vec 2 T No

25. Was case referred to medical examinar? 1 ☐ Yes 2 ☐ No		26. Place of Death (Check only one)								
		lospitat: 1 Inpatient 2	ER/Outpatient	loma 5 ☐ Residence 6 ☐ Other (Specify)						
Z L Accident	igation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicida deten		28a. Place of Injury - At h building, etc. (Speci	oma, farm, streety)	28f. Location (Street and Number or Rural Route Number City or Town, Stata)						

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who complated call death (Item 234) (Type, Print)

Barbara A. Parey, MD MIW. High St., Suite 310, Elkton, MD 21921

State Registrar

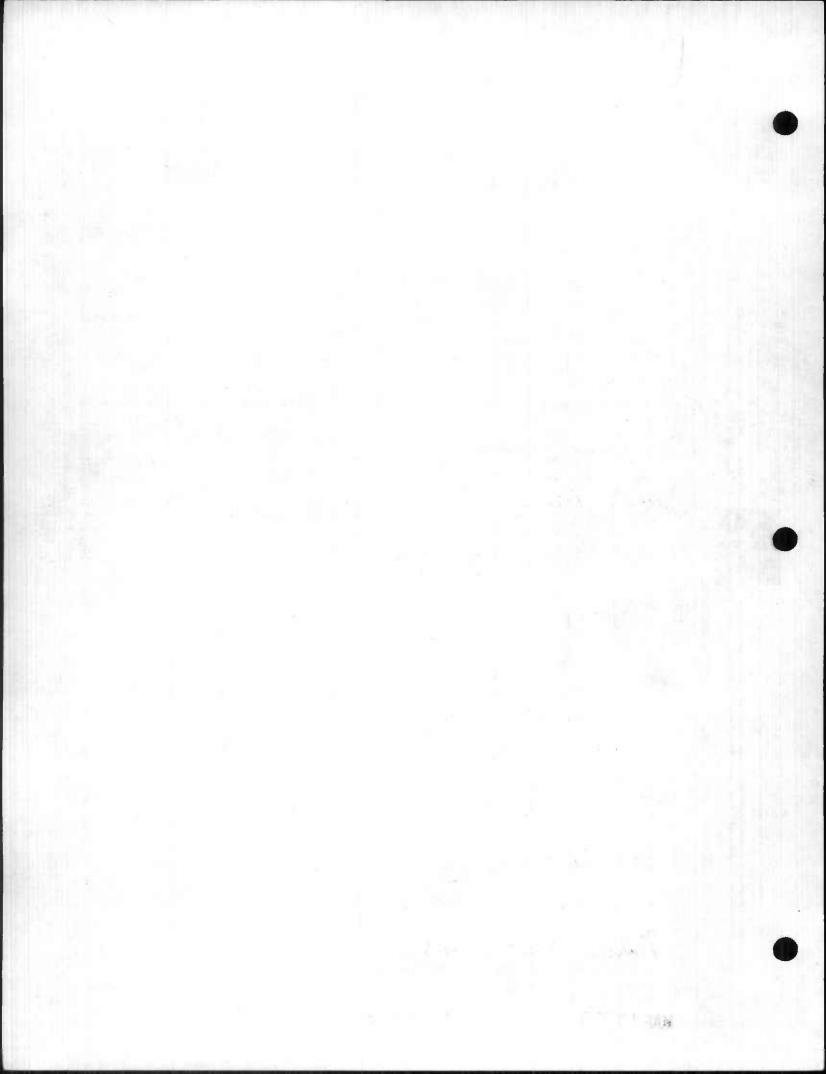
20 + IVA

32. Registrar's Signature

				(Certific	ate o	of Death		Reg. No.				
	1. Decedent's Nama (First, Middle, L	ast)						2. Data of I	Death		3. Time of Death		
Physician	Arthur J. Baker								8, 2000	Year	3:20 pm		
/Medica Examine	4a Facility Name (If not institution, g	iva street and number)	-				4b. City, Town	, or Location of De		y of Deeth	O.LO pin		
Examine							D	Delah					
	VA Maryland Hea 5. Social Security Number 6.		ystem e (In yrs. I		relev) If Ur	nder 1 Ye		Foint Hrs. 8 Date of F	Cec	T	olana (Stata or Foreign		
Funeral	222-12-3069	12 M 2□ F	72		rs. Mont			Min. 8. Dete of E	Day, Year)	Cour	placa (Steta or Foreign		
Director	Usual Residence of Decedent							may 0	1727	MITIM	ington Delaware		
1.	10a. State 10b. County		10c. City	. Town	or Location						10d. Inside City Limits		
ahow a		1-									1 ☐ Yas 2 ☑ No		
Double Double	Delaware New Ca	stie	Bea	r							10169 263140		
be notified	10e. Street and Number				10f.	. Zip Coo	de		10g. Citizen of	What Cour	ntry?		
	217 Forrestal Drive 19701 U.S.A.												
Pureral	11. Maritai Status	12. Was Decedent	Ever in U.	S.	13. Was De	ecedent	of Hispanic Origin	? (Specify Yes or fuerto Rican, atc.)	14. Ra	ce - Americ			
9 4	1 Never Married 2 Merried	Amed Forces? 1 2 Yes 2 1	anua	7.4		2.0		uerto riicari, atc.)		ck, White,			
1	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	24. 1	947	1 ∐ Ye	s 28	No Specify:		Speci	y: Wh:	Ite		
2	15. Decedent's I			160 [Decedent's U	Usual Oc	cupation		16b. Kind of B	Business/In	duatry		
it, the Medical	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)						working						
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ò	17. Father's Name (First, Middle, Las	1)			DI	1.40.		Name (First, Midd		_	tation		
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5								Wright					
	19a. Informent'a Neme/Relationship	(Type, Print)			_			or Rural Route Nun		, Stata, Zip	Code)		
	George B. Bucklew			21	/ Forr	resta	al Drive	Bear, D	elaware	1970	01		
	20a. Method of Disposition		20b. P	lace of I	Disposition ((Name of	place) M :	arch 13,	20c. Location	- City or Tr	own, Stete		
	14 Burial 2 Cremation 3							arten 13,	Bear	Dolar	1270		
	21. Signeture of Funeral Service Licenses 22. Name and Address of Facility										vale		
ouc	Crouch Funeral Home												
	Well O. M.	me			127 S	outh	n Main St	reet Nor	th East,	Mary	land 2190		
-	23a. Part1. Enter the disease, or con shock, or heart feilure. List onl	nplications that caused y one cause on each li	the death	n. Do no	ot enter the r	mode of	dying, such as car	rdiac or respiretory	errest,		Approximete Interval Between		
ian													
ical	Immediate Cause (Final disease or condition	Aspira	ation	nne	eumon i					3	16 days		
ner	resulting in death)	a. ADDIL	110000000000000000000000000000000000000		onsequence					1	It days		
1			Doe to (or	as a C	orisequence	oi).				1			
edicai Examiner		b								1			
X	Sequentially list conditions, if any, leading to immediate		Due to (or	as a co	onsequence	of):				1			
	ceuse. Enter Underlying Cause (Disease or injury	if any, leading to immediate cause. Enter Underlying C											
0	that initiated events resulting in death) Last	a	Due to (or	as a co	onsequence	of):							
Me													
		d								1			
Physician/	Part II. Other significant conditions	contributing to death b	ut not resu	iltina in	the underlying	ng cause	given in Part I.	23b. Di	d tobacco usa c	ontribute t	o the cause of death?		
hvs									23b. Did tobacco usa contributa to the cause of death 1 Yes 2 No 3 Probably 4 Unknow				
9	Chronic cbstr	uctive pul	morar	y d	isease	3			ee	0_1.70	-EI OHKHOWI		
A b								24a W	as an autopsy	24b. W	fere autopsy findings		
ete	Dysthmia							pe	formed?	87	vailable prior to empletion of cause		
Q								_		of	death?		
Completed								10	¥es 2□No	t f	☐ Yas 2☐ No		
Be	25. Was case referred to medical						26. Place of	Death (Check on)	y one)				
ToE	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆	ER/Out	patient 3	DOA	Other	ng Home 5□Re		her (Speci	(v)		
1	27. Manner of Death			28b. Ti					e how injury occu		.,,,		
0	1 Natural 5 Pending	28a. Date of Inju (Month, Da)	y Year)		jury M		Injury et Work? 1 ☐ Yes 2 ☐ No	3.5					
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TIT	4 Homicide determine		ury - At ho c. (Specify	me, ferr	m, street, fac	ctory, off	100	28f. Location City or 7	(Street and Num own, State)	per or Run	al Route Number,		
Ce													
edicai Certification:		hysician: To the best											
B	(Check only 2 Medical Exa	miner: On the basis of and manner sta	examinat ated.	ion and/	or investiga	tion, in n	ny opinion, death (occurred at the tim	e, date end place	, and due t	o ma cause(s)		
×	29b. Signature and title of certifier	^				29c. Lic	ense number		29d. Date sign	ed (Month,	Dey, Year)		
	Mallana	(an too	1.	2									
1/4-	7-100000	200101	1M:	(J)		1510	094-1		March 8	, 200)()		
HUA	30. Name and address of person who												
ME,L	ECIA SANTOS, M.D.,	VA Maryla	nd He	ealt	h Care	e Sy	stem, Pe	rry Point	, MD 2	1902			
	04 0 11 11 1 11 1 11 11 11 11 11 11					_							

DHMH 16 Rav 6/95

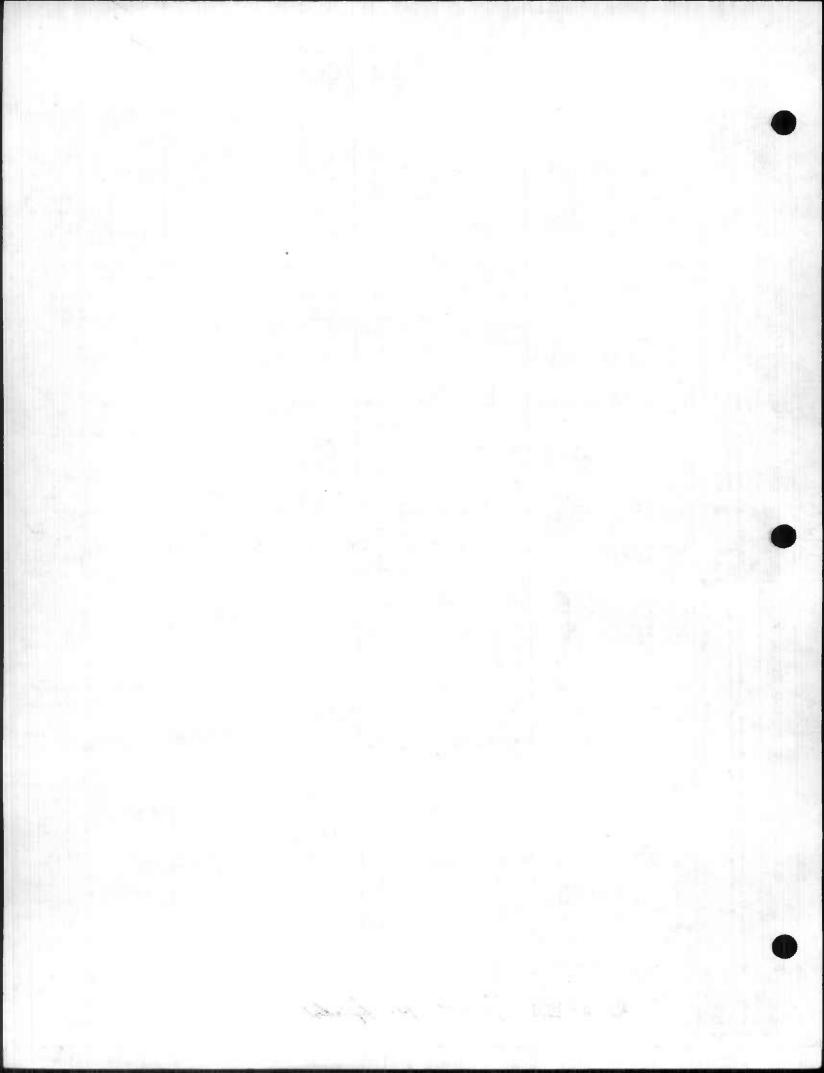
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9573 Certificate of Death

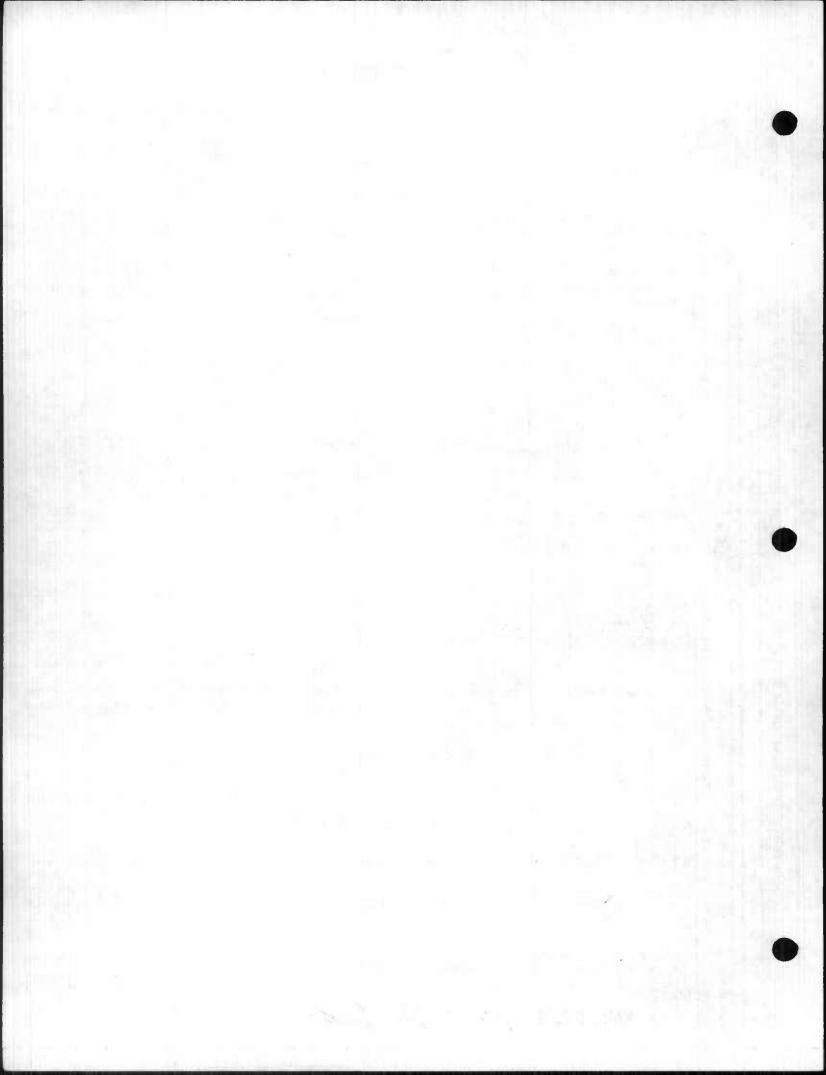
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/Medical	Rosa Spar	ks Baublit:	Z			Marc	h 4",Z	1000 4, ZV 171	
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	Carroll Co.	my is	124 01	1100	VVVJW	11,4>+m	Co	77 7 07/	
Funeral Pirector	5. Social Security Number 6. S 220–16–3621 Usual Residence of Decedent	Sex 7. Age (In 82	yrs. last birtho	Months Days	If Under 24 Hrs Hours Min.		1918	9. Birthplace (State or Foreign Country) North Carolina	
B m	10a. Stele 10b. County	100	. City, Town o	r Location				10d. triside City Limits	
nut be notified.	Maryland carrol	1		10f. Zip Code	Westminst	er	1 ☐ Yes 2XIN		
ner must be n uneral Dir	10e. Street and Number 2019 Stone Road	10g. Citizen of WI							
by Fune	11. Marilel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	in U,S.	13. Wes Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No		pecify Yes or No to Rican, etc.)	14. Race Black Specify:	- American Indian, c, White, etc. White	
a pot	15. Decedent's E (Specify only highest gro		16a. De	ecedent's Usual Occu	pation during most of wo	rkina	16b. Kind of Bus	iness/Industry	
Completed	Elementery/Secondery (0-12)	College (1-4or 5+)		life. DO NOT use retired) Housewife			Ov	Own Home	
Be	17. Father's Neme (First, Middle, Last				18. Mother's Nar	ne (First, Middle	, Maiden Sumame)	
ToB	Dewey Sparks				Cecili	a Yelto	n		
	19e. Informent's Name/Reletionship (George Baublitz	10.00	eiling Address (Street)						
5	20e. Method of Disposition 1 28 Burial 2 Cremetion 3	Removel from State	b. Plece of Di cemetery,	sposition (Name of cremetory or other ple	ice)	Date 3/07	20c. Localion - C	City or Town, State	
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ation: T	27. Menoer of Daath 1 Naturel 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Dey Yea		e of 28c. Inju		T -	how injury occurre		
ed in by the funeri Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, ferm, ecity)	, street, factory, office		28f. Location (City or To		or or Rural Route Number,	
dical	29a. Certifier Check only one) Certifying Ph	ysician: To the best of my ninar; On the basis of examend menner steted.	knowledge, deninetion end/o	eath occurred at the ti r investigation, in my	me, date and place opinion, death occu	, and due to the irred et the time,	cause(s) and man date end plece, as	ner as stated. nd due to the cause(s)	
Me M	29b. Signature and title)of certifier	1		29c. Licen	se number		29d. Date signed	(Month, Day, Year)	
	1-8-	t,		14	8006	1	manch	4th, 2000	
	30. Name end address of person who	HITTY, "	200	pe, Print) ML m 1	rial H	tua, V	V-157mins	sty MD 21157	
State Registrar	31. Dete filed (Month, Day, Year) MAR 0 8 2	32. Registrer's S	igneture	9. Spore	h	,		/	

DHMH 16 Rev 6/95



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			Cert	ificate of	Death	F	Reg. No.			
	1. Decedent's Nama (First, Middla, Last)				2. Date of Dea	ith	Vaca	Tima of Death	
Physician /Medical	Charles Ed	ward Ballar	d			Tarch	5, 20	00	9:56 Am	
Examiner	4a Facility Nama (If not institution, giva	street and number)		4	45. Oity, Town, or	Location of Death	4c. County o			
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a Maryti lari sho diffed at	Maryland Baltimore Timonium 10e. Sfreet and Number 10g. Citizen of What Country?									
death with the Maryla me 23e or 28e-f sho maxt be notified at maxt be notified at neral Director	10e. Street and Number 11 Bailiffs Court	What Country? SA								
020 un after des aft, or Hems Examiner, m	3 ☑ Widowed 4 ☐ Divorced		as Decedent of I as, epecify Cub		Specify Yas or No- to Rican, atc.)	o- 14. Race - American Indian, Black, White, atc. Specify: White				
72 hs 72 hs Manual Ma Manual Manual Manual Manual Ma Manual Ma Manual Ma Manual Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma M	15. Decedent's Edu (Specify only highest grad		16a. Deceder	nt's Usual Occup nd of work dona	pation during most of wo	orking	16b. Kind of Bus	sinass/Industry	1	
I 21215-0 ad within 72 ho yglene, we than 'naturi it, the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retire .ectrici	during most of wo		Commerc	ial El	ectric	
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land of trever	Charles Ballard				Cora M	Maloen Symaney				
and Management	t9a. Informant's Name/Ralationship (T)	/pe, Print)	19b. Mailing	Addrass (Street			r, City or Town, S	Town, Stata, Zip Code)		
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Baltimore, emit. Pages 1 s Popartment of the movingers or othe my injury or othe face.	20e. Mathod of Disposition 1 ⊠ Burial 2 □ Cramation 3 □F 4 □ Donation 5 □ Other (Specify)	semover from Stere	Place of Disposit cematary, crama illers (Data 3/08	20c. Location - 0		itata	
Baltii Permit. P Department important any inter-	21. Signefura of Funaral Sarvice Licens		- 22. N	Nama and Addre	ass of Facility	Eline Fu St, Hamps	neral Ho	me		
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Physician /Medical Examiner popularity popularity popularity page 12 per	Immediata Cause (Finel diseesa or condition rasulting in death) Sequentially list conditions,	Chron:	or as a conseque	68tz	octive	chung	Disea	se		
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Ne se de						24a. Was an autopsy performed?			utopsy findings e prior to fion of cause 1?	
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C State	27. Manner of Death 1 X Natural 5 Pending invastigation	28a. Data of Injury (Month, Day Year)	7) 28b. Tima of 28c. Injury at Work? 1 \[Yas 2 \] No			28d. Describe how injury occurred				
Division of To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: Affart completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be 4 Homicide datarmined	3 Suicide 6 Could not be 28a, Place of Injury - At home, farm, street, factory, office 28f, Location (Street is							ita Number,	
Me Hospit n 24 hour We Funeri pletely fill	29a. Certifiar (Check only and) Medical Exami	sician: To the best of my knowner: On the basis of examina and manner stated.	owledga, daath o ation and/or inva-	ccurred at tha ti stigation, in my	ma, data and plac opinion, daath occ	e, and dua to the durred at tha tima, d	cause(s) and mar data and place, a	nnar as stated. nd dua to tha	cause(s)	
Within To the compl	29b. Signature and title of certifier		derson	29c. Licans	sa number	1	29d. Data signed	(Month, Day,	Year)	
	Mich de	(ax) Phil	516100	RD	19671	7	3/5/2	THE		
	30, Nama and addrass of person who co	ompleted causa of death (Ites	n 23a) (Type, Pr	int) 1	0	5 0	1 100	1		
11.14.2	Mary Beth H	nderson MI	1000	Frankli.	1 Square	Vive Bo	Himore	MD	2/237	
State Registrar	31. Data filed (Mohth, Day, Year) MAD A 200	32. Registrar's Signa	atura 4	1000						



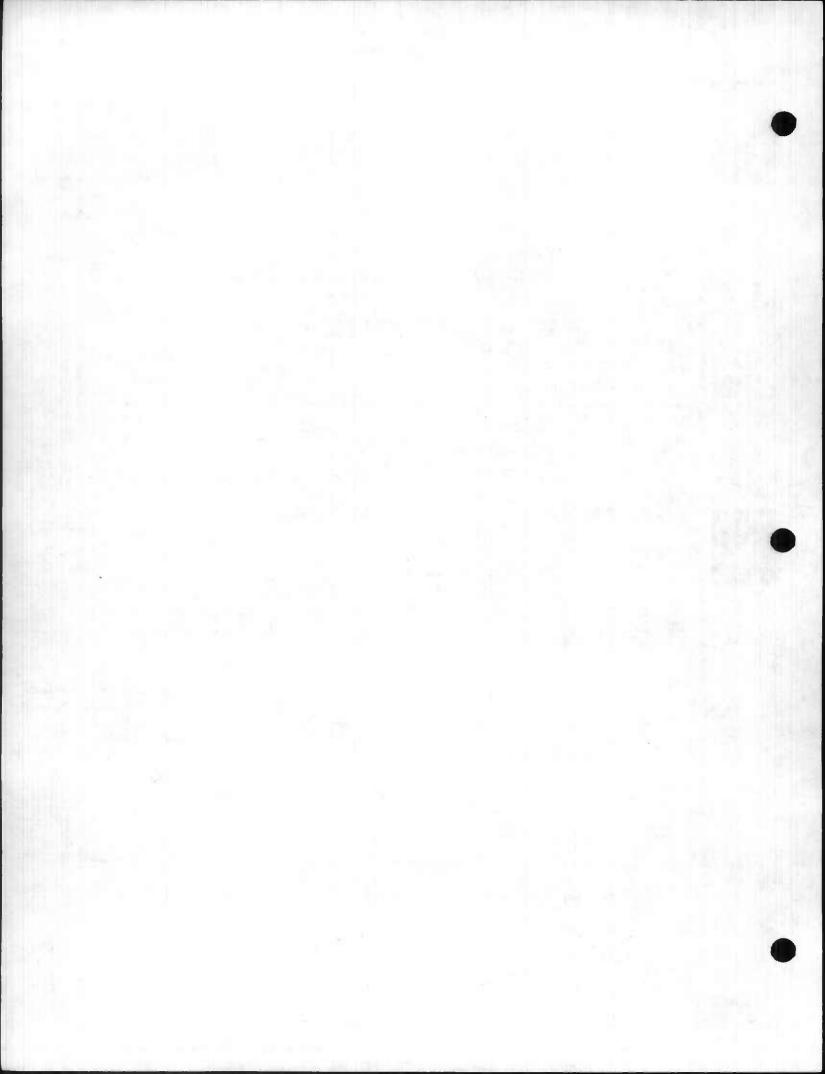
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2 Date of Death 3. Time of Death bernice, Kopp, Brilhart War ch 15 2000 4:16pm **Physician** /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Husmital byera Wishminsth Carroll CPUNT Carrol If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** Days 220-36-8125 10 M 200F 99 Yrs. Director marylana Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits must be notified at Carroll MD Westminster Yes 2 No Director 10e. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? St. Mark Way apt 215 21158 USA Funeral 14. Race - Amarican Indian, Bleck, White, etc. 12. Wes Decedent Evar in U,S Armed Forces? "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Nevar Married 2 Married ☐ Yas 2 No Yes, Give 1 Yes 2 No aitimore, Maryland 21215-0020 Specify: White Specify: py 3 Widowed 4 □ Divorced Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Schoo eacher parmit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg important: if hem 27 is marked other any injury or other traumes. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be margaret Stough William 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
320 College VIEW BIVD WESTMINSTER, MD, 21158 19s. Informent's Neme/Reletionship (Type, Print) Nancy hoontz/daughter 20b. Plece of Disposition (Name of 20a. Method of Disposition

1 Description 2 Cremetion 3 Removal from Stete 20c. Location - City or Town, Stete Dete cemalery, cremetory or other piece)
-INEDO TO CEMETURY 03/07/00 Lineboro, maryland 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Fecility Pritts Funeral
412 Washington ed We 21. Signeture of Funeral Service Licensee Hom Westminster 1 23a. Part Enter the disease, or complications thet daused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Daeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) Examiner cancer WO WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last by Physician/Medical Dua to (or as a consequence of): 4 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown Orpno Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 2000 1 Yes Division of Vitai B 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1□ Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Duhpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Attending 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death. The Funeral Director: A pletaly filled in by the fi death. investigetion 2 Accident 6 ☐ Could not ba 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 6 Hospital Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29b. Signeture and title of certified 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wishmonster MD 2197 20 150 U 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar MAR 0 6 2000

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notified at the Maryla or hams 23s or aminer must be 72 hours after Hyglane. Pages 1 and 2 should be fit ment of Health and Mental H ann; if Item 27 is marked oth lury or other traumatic aven

Julius

Boots,

21215-0020

Maryland Baltimore, **Physician** /Medical

Examiner sician and buriai-transit The law requires that the death certificate be assouted physician the burla P.O. Box 68760 2 188 been signed by the a should be detached Records, page 2 certificata Division of Vital or Attending Physician: funeral director, After this To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al filled in by

1. Decedent's Name (First, Middle, Last) 3. Tima of Death Year Julius Boots, Jr. 2000 5:50 a.m. fairch 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death VA 'EDICAL CENTER, FORT HOWARD, MD 21052 FORT HOWARD If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Days Months Hours 11 M 20 F Country) Maryland 216-30-3838 **Usual Residence of Decedent** 10e State 10b. County 10c. City, Town or Location 10d Inside City Limite 1 Yes 2□ No Director Maryland N/A Baltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 1103 Forrest Street 21202 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 N Yes 2 No 1953-If Yes, Give 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced 1955 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Power Plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Julius Washington Boots, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Owens/Daughter Baltimore, MD 21202 1103 Forrest St. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removel from State Maryland Veterans' Cem. 3/10/00 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licenses 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Colon Cancer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 48 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 25 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No DOA 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Middigni) D51493 3-5-2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANWER SIDDIQUI, M.D., 9609 WORTH POINT ROAD, FORT HOWARD, MARYLAND 21052 31. Date filed (Month, Day, Year) 32. Registra/'s Signature State

DHMH 16 Rev 6/95

Registrar

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MAR 0 9 2000

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LANDS & MALE TO AN EXP

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death Month 3. Tima of Death **Physician** Garfield Booth 11, March 2000 1020 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Jan. 14, 1911 6. Sex 1 M 2 F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 89 578-16-8079 Yrs. Director Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show 1 Yes 2 No Director Maryland Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20736 205 Skinners Turn Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if flem 27 is merked other than "natural", or fle any injury or other traumatic event, the Medical Exercise any injury or other traumatic event, the Medical Exercise Propose. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 3 Boiler Plant Engineer Public School 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John William Booth Becky Emerson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Rosie Booth/Wife 205 Skinners Turn Road Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Surial 2 Cramation 3 Removal from State Mt. Hope UMC Cemetery 3/16/00 | Sunderland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licensee Sewell 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immedieta Cause (Final disease or condition resulting in death) /Medical METASTATIC GASTRIC ADENDEARCIDOMA UNKNOW Examiner Due to (or as a consequence of) Examiner COPO The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical Due to (or as a consequence of): 4SP P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown NOWS signed b Be Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes No certificate of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Lopatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Netural 2 Accident 5 Pending 24 hours after death. t ☐ Yes 2 ☐ No investigetion NIA 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Cartifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) within 2 To the I \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier D39037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTE REUNDEL MEDICAL CLOTTE ANNASOLIS DOUGLAS S MITCHELL 31. Date tiled (Month, Day, Year) 32. Registrar's Signeture State MAR 1 5 2000 > Registrar

DHMH 16 Rev 6/95

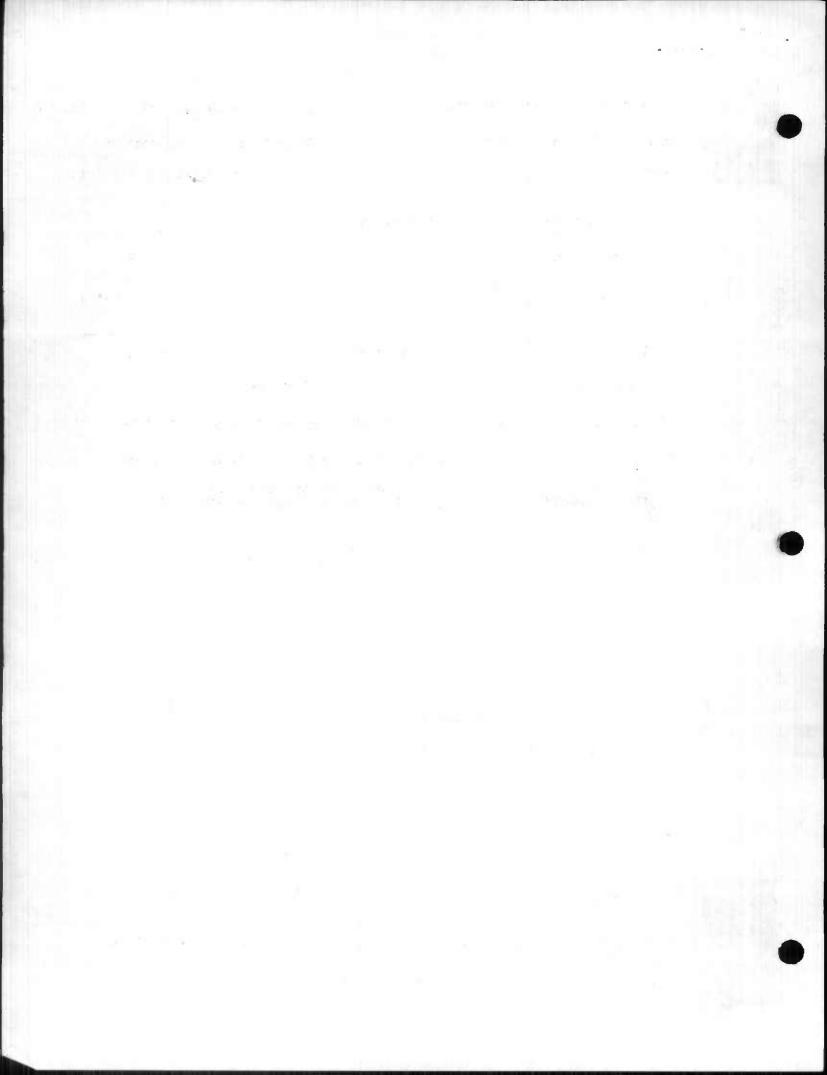
and from the family

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State of Maryland / Department of Health and Mental Hygiene 00 09578

							Cer	tificate of	Death		Re	g. No.		
			1. Decedent's Name (First, Middle, La	ist)						2. Data			Year	3. Time of Death
	Physician /Medicai		Cecelia D	ean B	rooke	е						, 2000	real	4:56 AM
	Examir		4a. Facility Name (If not institution, given	e street and num	n <i>ber)</i>				4b. City, Town	, or Location of	Death	4c. County	of Death	
			Dorchester Genera	al Hospi	tal					ridge		Dorc	heste	er
	Funerai Director		578-16-9807	Sex 1□M XXXF	7. Age (In y 82		hday) rs.	If Undar 1 Year Months Days			h, Day,	Year) 917	9. Births Cour Virg	placa (State or Foreign ntry) ginia
	with the Maryland a or 28a-f show be not'fied at	lor	Usual Residence of Decedent 10a. State 10b. County Maryland Dorche	etor	10c.	City, Towr							1	10d. fnside City Limits ▼▼Yes 2□No
	the 289	rec	10e. Street and Number	socei		Va	Cambridge 10f. Zip Code			10		log. Citizan of What Country?		ntry?
	With Se or	Funeral Director	520 Glenburn Aven	110					613					
	deeth	Jera	11. Marital Status	12. Was Dece		ı U,S.	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexicen, Puerto Ricen, et				US es or No- 14. Race - Am			
020	72 hours after deeth with the Maryland natural; or items 23s or 28s-f show dest Examiner must be notified at	by	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ▓ Divorced	Armed Forces? 1 Yas 2 No If Yes, Give Year or Dates:				Yes, specify Cub ☐ Yes 2 No						atc. nite
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Maryland 21215-0020	E 1.8	Completed	Elamantary/Secondary (0-12)	College (1-4or 5+)					na during most of working tired)			0 ***		
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re,	- 9 E E		20a. Method of Disposition	inc b		Piece of	Dispos	ition (Name of		Data	2	Oc. Location -	City or To	own, State
altimore,	00 - 7		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contro		State			veteran		3/13/0	0	Hurl	lock,	Maryland
Balti	permit. Pag Department Important: It any Injury o		21, Signature d'Funeral Service Lice				22.	Name and Addr	ess of Facility	I D				
	Physician /Medicai Examiner		23a. Parm Enter the disease, or comshoul, or heart failura. List only Immediata Causa (Final disease or condition resulting in death)	pplications that connections cause on e	/	eath. Do n	st	inal	_	truction		e, mar	1	Approximate Interval Batween Onset and Death
ox 68760,	2 5 6	VMedical Examiner	Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Disasas or injury that initiated events resulting in death) Last	b		o (or as a c								
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0		by P	Chronic	Sch	GOPA	ren	ia				10 19	20110	30710	Debty 4 Onknown
Records,	aw requires been s	Completed b	- Chronic Hypothyro	oidism	7,	An	er	nia		248.	Was an	autopsy ned?	av	era autopsy findings railabla prior to empiation of cause death?
	The law ete hes b page 2 s	E O	// /								1 ☐ Ye	s 2 No	1[☐ Yes 2☐ No
ita	ysiclan: The	Be (25. Was case referred to medical examiner?						26. Place of	Death (Check	only one	9)	-	
Division of Vital	g Phys er this seral di	Certification: To	1 Yas 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Data d (Mont			ime of njury	28c. Inju			-	nce 6 D0th w injury occurr		ν)
Divis	可其六日	Certific	3 Suicide 4 Homicide Could not be datarminad 28e. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)								al Route Number,			
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Property 2 Madical Example (Check only one)	niner: On the be	best of my lesis of exam ner stated.	knowledge ination and	death dor inv	occurred at the t astigation, in my	ime, date and p opinion, daath	place, and due to occurred at the	o tha ca time, da	use(s) and ma ta and place,	annar as s and due t	tatad. o the cause(s)
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			30. Name and address of parson who Eyup Tanma	complated caus		tem 23a) (Type, I	rint)	ct. Ca	mbrid	ze,	MD 21	1613	2
	Sta Registr	_	31. Data filed (Month, Day, Year) MAR 1 0 20	000 32. B	gistrar's Si	gnature	6.	Sport	41					

Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 09579

					Certificate of	of Death	R	eg. No.	05313	
Physicia		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dear		3. Time of Death	
/Medic		Loretta Th	eresa	Banc	roft		March 6		12:51 pm	
Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, o	r Location of Death	4c. County of	Death	
والصراكة		Washington Adve	ntist Hospit	al		Takoma	Park	Montgo	omery	
Funeral			Sex 7. Age (In	yrs. last bir	Months Da			Year)	9. Birthplace (State or Foreign Country)	
Director		578-24-3650 Usual Residence of Decedent	7	5	Yrs.		Oct. 24	, 1924 V	Vashington, DC	
how		10a. State 10b. County	10	c. City, Towr	or Location				10d. Inside City Limits	
uth with the Marylan 23s or 28s-f show	Director	Maryland Prince George's Hyattsville						1 🖳 Yes 2 🗆 No		
or 2	Olre	10e. Street and Number			10f. Zip Cod	е	1	0g. Citizen of Wh	nat Country?	
23a		4008 Emerson S	treet		20	781		U.S.A.		
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Maryland than and Mental Hygiene. If it marked other than "netural", or items 23a or 28s-f show traumatic event, in a Medical Examiner must be notified.	by Fune	by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	in U,S.	13. Was Decedent of If Yes, specify C		(Specify Yes or No- erto Rican, etc.)	Black,	American Indian, White, etc.
n 72 hours		15. Decadent's E		16a.	Decedent's Usual Oc	cupation	White			
218 hin 7 Med Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)						Medical	Insurance	
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nd e file other	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's N	ame (First, Middle, I	Maiden Sumame)		
/lanuld build b	ToB	Clarence G. B	eatley			Virgi	nia Marr			
ary s me		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Str	eet and Number or F	Rural Route Number	, City or Town, S	tate, Zip Code)	
		Robert W. Bancrof	t - Husband	400	08 Emerson	Street,	Hyattsvil	le, Mary	land 20781	
ore, Maryland 2. Jes 1 end 2 should be filed v of Health and Mental Hygies if them 27 is marked other it y other traumatic event, in		20a. Method of Disposition	2	0b. Place oi	Disposition (Name of y, crematory or other p	place)	Date	20c. Location - C	ity or Town, State	
Pag nent mrt: It		1 ☑ Buriai 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	fy)		Lincoln Ce	metery	3/10/2000	Brentwo	od, Maryland	
Balt permit. Departr Imports any Inje		Claudett	J. Das	ach	Gasch's 4739 Bal	Funeral H	ome, P.A. enue, Hya	ttsville	e, MD 20781	
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the one cause on each line.	death. Do n	ot enter the mode of	dylng, such as cardi	ac or respiratory arm	est,	Approximate interval Between	
Physician	- 1								Onset and Death	
/Medicai Examiner		Immediate Cause (Final disease or condition	a A RT/PU	SCLAR	WAC CAR	DIAC DI	SLAIK		5+76ARS	
LAMINITE	er	resulting in death)		-	onsequence oi):					
, P.O. Box 68760, that the death certificate be executed ed by the ettending physician and detached for use as the buriel-transit	clan/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	C		onsequence oi):				
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The I	NO.						1 □ Y€	s 2 No	1 ☐ Yes 2 ☐ No	
Vital I	Be	25. Was case referred to medical				26. Place of De	eath (Check only on	e)		
- 5 w D	To	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Out	patient 3 DOA	Other: 4 Nursing	Home 5 ☐ Reside	ence 6 Other	(Specify)	
After fune			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. T		njuryai Vork? □ Yes 2 □ No		w Injury occurred	
Division Tor Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - building, etc. (S	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Hospi 24 hou Funer stely til	edical C	29a. Certifier (Check only one)	nysician: To the best of my miner: On the basis of exa and manner stated.	knowledge, mination and	death occurred at the Vor Investigation, In m	time, date and place y opinion, death occ	ce, and due to the co curred at the time, do	ause(s) and manr ate and placa, an	ner ss stated. d due io ihe cause(s)	
To the Mithin To the comple	Me	29b. Signature and title of certifier	and married states.		29c. Lice	ense number	2	9d. Date signed ((Month, Day, Year)	
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Stat Registra		31. Date illed (Month, Day, Year)	37. Registrar's S	Signature	sports					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 09580 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:25 P.M. Mayor 4. 2000 Renee Eugenia BaiLey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Examiner Mariner Health Care Of Greater LaureL LaureL 5 Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth August Dan Year 1957 9. Birthplace (State or Foraign V 1997) a **Funeral** 1 M XXF Days 42 Yrs. 577-76-2213 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Director MaryLand Prince George's Lanham 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 9751 Good Luck Road #9 20706-3349 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 [2] No If Yes, Give Year or Dates: 14. Race - Americen Indian, Black, White, etc. BLack Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 Never Married 2 Marriad 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Dahn Corporation Manager 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa L. Sanders WilLiam ALLen 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number of Flural Flouts Number, City of Town State Zip Code) 9751 Good Luck Road #9 Lanham, MaryLand 20706-3349 Mr. Richard E. BaiLey (Husband) 20b. Place of Disposition (Name of Chesalter Renator (Sec.) Inc. 20a. Method of Disposition 3/8/2000 BeLtsville, MaryLand 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State ation 5 Other (Specify) of Funaral Service Licensee 22. ROLL ATRISOT SHEET ABILITY OME. INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one ceuse on each line. **Physician** Neorlow /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was en eutopsy performed? 1 Tes 280No 1 ☐ Yes 2 ₺No 25. Wes cese referred to medicat examiner? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNeturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcida 6 Could not be 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide edical 29a. Certifier 1 KCertifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and plece, and due to the ceuse(s) and manner stated. 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) March 7, 2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 8317 Cherry Lane, Laure | Md 20707 Kundvat, M.O.

State Registrar

31. Date filed (Month, Day, Year)

MAR 0 8 2000

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Baltimore, Maryland 21215-0020

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To the Hospital or Attendir within 24 hours after daath.

To the Funeral Director: At completely filled in by the fu

The law requires that the death certificate be executed

Hospital or Attending Physician:

daath.

Division of Vital Records, P.O. Box 68760.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 09581. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Das Month CHARLES W. BROWN March 7, 2000 ation of Death 4c. County of Death 10:36 A.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton, Maryland Prince George's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2□ F Days Months Hours 223-54-5384 56 Sept. 25, 1943 Virginia Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Ves 2 No Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 County Road #-T3 20747 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give X Year or Detes: 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Glass Cutter 10th Grade Federal Government 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Adolphus P. Brown Ruth G. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Beverly J. Brown (Wife) 1900 County Road #-T3 District Heights Maryland 20b. Place of Disposition (Nama of cemetery, crematory or other plece) 20c. Location - City or Town, State 20747 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Harmony Memorial Park 03-14-2000 Landover, Maryland 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4339 Hunt Place, N.E. Washington, D.C. 20019 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on aech line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) 50 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy lindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Netural

The lew requires that the death certificate be assouted the buriel-tran P.O. Box 68760, signed by the at d be detached for Division of Vital Records,

Physician

Examiner

/Medical

Examiner

Physician/Medical

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Be Completed

Medical Certification: To

certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director;

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours efter death with the Marylan Department of Health and Mentai thyglena. Important: if item 27 is marked other than "natural", or heme 23a or 28a-1 show any futury or other traumatic event, the Medical Expenses that the hours and pages.

21215-0020

Baltimore, Maryland

25. Was case referred to medical examiner? 1□ Yes 2FTNo

> 2 Accident 3 Suicide

> 4 Homicide

29a. Certifie

5 Pending investigation

28a. Data of Injury (Month, Day Year) 6 Could not be 28e. Place of Injury - At homa, larm, street, lactory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of conflict MID

00052741

29c. License number

29d. Data signed (Month, Day, Year) 03/08/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caroline Cainc 9131 Piscataway Rd Clinton MD

State Registrar 31. Date filed (Month, Day, Year)
MAR 1 0 2000

Registrar's Signeture

Physici /Medi Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglens. Important: If them 27 is marked other than "natural", or hams 23s or 28s-f show any injury or other treumatic avent, the Medical Examiner must be notified at ence.

Physician /Medical Examiner

To the Hoapital or Attending Physicien: The law requires that the death certificate be asscuted within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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5822 DEWEY STREE	201	umbory			CHEVE				VCE GI		C
	i. Sex	7 Age /In wrs	s. last birthday)	If Under 1 Yee			8 Date of B				
232-44-8056	1□M 2∏F	73	Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, D December	6,192	6 Wes	t Vir	tete or Fore
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											Yes 2
Saryland Prince (Oe. Street and Number	George's	Cl Cl	neverly	10f. Zip Code				10g. Citizen	of What Co	1 21	
822 Dewey Stree	+			20705				II C A			
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3 ☑ Widowed 4 □ Divorced 15. Decedent's	Year or I	Dates:		dent's Usuel Occu			-	16b. Kind d	-		
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Community/Securically (U-12)	1	(1-4or 5+)	Admin	istrativ	e Off	icer		Federa	al Go	vernm	nent
7. Father's Name (First, Middle, La	ist)				18. Moth	er's Nam	e (First, Middle				
Iria Issac Cop	elan				Art	ie Ma	ay Zirk	1e		7.11	
9a. Informant's Name/Relationship	(Type, Print)		19b. Meili	ng Address (Stree	et end Numb	er or Rur	al Route Numi	ber, City or To	wn, State,	Zip Code)	
Sherron J. Apper	son – Da	ughter	34831	Paxson	Road,	Rour	nd Hill	, Virg	inia	20141	
On. Method of Disposition			Place of Dispo	osition (Name of metory or other pl			Date	20c. Locati			
1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				tan Cren		13	1/2/2000	Alevan	dria	Vir	oinie
1. Signature of Funeral Service Lig		1		2. Name end Addr			4 2/ 2000	ALCAGI	urra,	VIII	STILTO
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Sta Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 27, 2000 February 11:00 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare at Knollwood Manor Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months Davs Hours 1 M 2 F 90 007-34-3937 June 19, Director 1909 Canada Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Directo 25a-f Maryland Anne Arundel Davidsonville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Harna 23a or 3673 Patuxent River Road 21035 Canada Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: 6 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) 8th College (1-4or 5+) permit. Pages 1 and 2 should be illed w Department of Health and Mental Hygien Important: If them 27 is marked other this any Injury or other the Maid Residential 17. Falher's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 88 Denis Pelletier Louise Michaud 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jeanette Johnson/ Daughter 3673 Patuxent River Road Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stale 1 Burial 2 Cremation 3 Removal from State 3-1-00 Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Fecility George P. Kalas Funeral Home 21. Signature of Funerel Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Vascular Diseuse oronary disease or condition resulting in deeth) Examiner Due to (or as a consequence of) and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): physician Box 68760 90 Physician/Medical the Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24e. Was an eutopsy performed? 24b. Wera autopsy findings available prior to Completed peen completion of cause of death? has 2 No 1 ☐ Yes 20 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical npletely (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Nama and address of person #1304 Gevernalark, MD 2114le 9 Jumps Hole (Month, Day, Year) 32 Registrar's Signature MAR 0 1 2000 Registrar

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State of Maryland / Department of Health and Mental Hygien 0 9584

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/Medical Examiner	4e Facility Neme (If not institution, give	re street end number)			4b. City, To	wn, or Location		4c. County	of Deeth			
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	30. Name and address of person who	completed cause of deeth (Ite	m 23a) (Type	Print)			^	1	-			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09585 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 29 2000 PORTCHES CLINTON FEB. 1:30 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death INTHICUIA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) MARCH 7 1 CHESAPEAKE HOSPICE HOUSE ANNE ARUNDEL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 15 M 2□ F 056-18-9390 1918 GEORGIA Usual Residence of Deceden 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes XXNo ANNAPOLIS MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2049 GATE DRIVE 21401 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? **DX*es 2□No If Yes, Give Year or Dates: 1935-39 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK Specify 34 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BEACON LANES Elementary/Secondary (0-12) College (1-4or 5+) BOWLING ALLEY 10th MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ISAIAH MACCLINTON ALICE Mcpherson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2049 GATE DRIVE ANNAPOLIS, MD. 21401 SHEILA CLINTON (DAUGHTER) 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 3/2/00 BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility eese Harry WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Between Onset and Death Immediate Cause (Final fr. Mes disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? respect 2 No 1 Yes 3 Probably 4 Unknown LN and 24b. Were autopsy findings svailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Margner of Deat 1 Substural 28h Time of 28c. Injury at Work?

Physician /Medical Examiner

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7 Is marked other than "natural", or items 23s or 28s-f show treumstic event, the Madical Examinar must be notified as

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other any Injury or other treumade event.

Baitimore, Maryland 21215-0020

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Box 68760. Division of Vital Records, P.O. al or Atternants after death.

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Registrar

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2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of Partifié

3∏ Suicide

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year)

2000

5 Pending investigation

6 ☐ Could not be

1833 A 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

treso

1 Yes 2 No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Data signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death February 27, 2000 4:42 pm **Physician** Georgia H. Carter /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Severna Park Anne Arundel 504 Pinetree Drive If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 € F 74 Months 256-32-4152 Yrs **Director** Jan 25, 1926 Georgia Usuel Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10d, Inside City Limits x 28a-f show 10b. County Anne Arudel Severna Park MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of health and Mental thysiene.

Int: If item 27 is marked other than "natural", or items 23a or intro or other traumatic svent, the Mental Example Inter 21146 USA 504 Pinetree Drive Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No It Yes, Give Year or Dates: 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: White Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Warren Keith Hollister Georgia DeLoach 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Dawn Knebel/ daughter 504 Pinetree Drive, Severna Park, MD 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Mar 8 Department of Important: If it any injury or or 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 2000 Arlington, VA Arlington National Cem. 21. Signature of Fundral Service in 22. Neme end Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 1.A. Severna Park runeral Holes for the first such as cardiac or respiretory arrest, Approximete as on each line. Approximete Interval Between Onset and Death Physician Breast Cancer /Medical Lause (Final years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) and Hran Exam Due to (or as a consequence of): certificate be exec physician a s the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 200 2 XNo 3 Probably 4 Unknown 2 signed b Py. 24b. Were autopsy findings available prior to completion of dause of death? 24a. Was an autopsy Completed page 2 1 Yes certificate director 80 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home St. Residence 6 Other (Specify) 10 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 100 27. Nagner of De 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Albac Attanding Natural Accident 5 Pending investigation 1 Yes 2 No after deatl Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 C Homicide A 24 hours he Funeral Die rilled iv Describing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifles Medical To the To To the To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tittle of certific CNCOLOGIST MD057546-L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Donegan, M.D., 89 MDOS/SGOMO 1050 West Perimeter Road, Andrews AFB, MD

Registrar

31. Date tiled (Month, Day, Year)

32. Registrer's Signeture MAR 0 3 2000

Please Type or Print in Black Indelible ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2000 William Clark Carlyle March 4 12:15pm 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Ives Drive Severna Park Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/4/1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 20 F Months Days Hours Min. 216-16-3926 77 Yrs. Maryland Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Saint Ives Drive 21146 United States Amerida 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Federal Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Columbus Gardner Clark Ida May Stinchcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Sue Clark / wife Saint Ives Drive Severna Park MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) 3/6/00 Catonsville, MD 4 Donation Metro Crematory 21. Signature of Fr eral Septice Listings 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park FH 23a. Page Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. 21146 Approximate Interval Between Onset and Death Immediate Cause (Finel CANCER OF PANZREAS METASTPITC disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 2 0 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

or Attending Physician:

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Physician/Medical Examiner Completed by Be Certification: To

25. Was case referred to medicat axaminer? 1 Yes 2 No

> 1 Natural
> 2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier

29c. License number 16

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (trem 23a) (Type, Print) GRARE 900 BESTGATE EDER

31. Dete filed (Month, Day, Year)

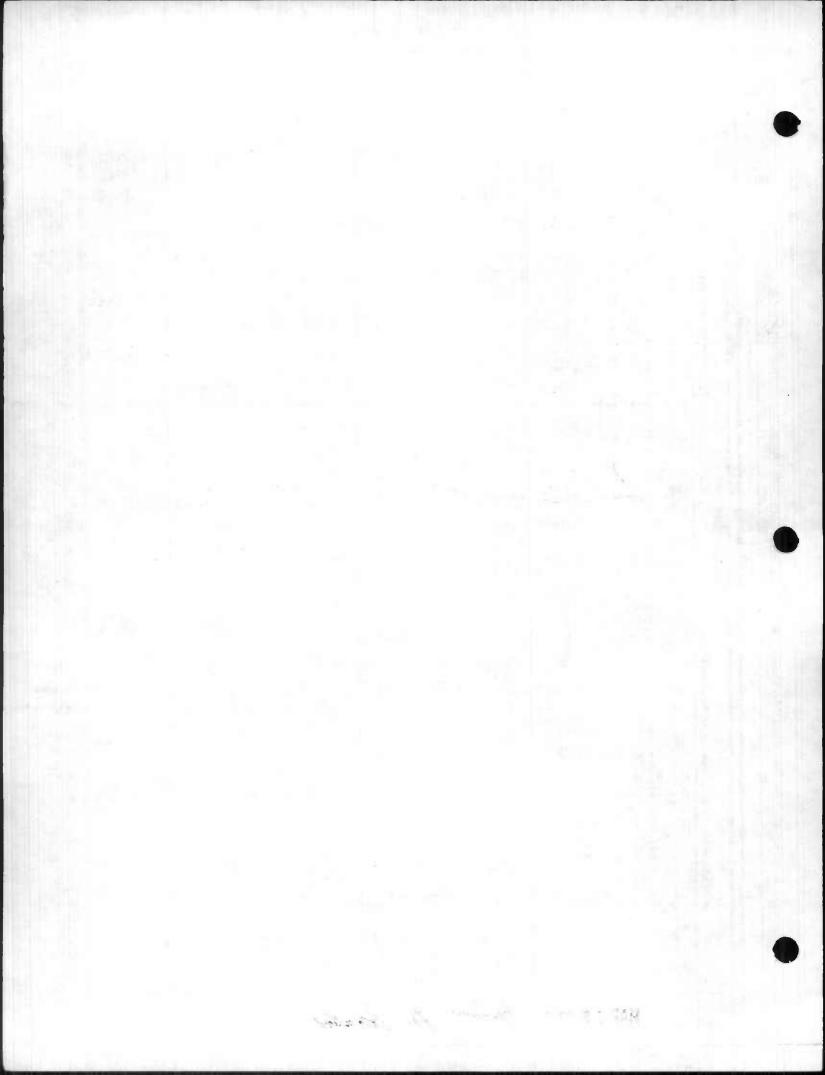
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32. Registrer's Signature

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State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year Ronald Edward Calder 2000 March 8:00 am 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1739 Grandview Rd. Pasadena Anne Arundel If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 11 M 2□ F 59 220-36-6093 Dec. 2, 1940 Canada Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1739 Grandview Rd. 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 TX Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 Machine Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald B. Calder Edna G. Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Calder/Wife 1739 Grandview Rd. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Mar 10 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove Imm State Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Glen Burnie, MD 21 Signature of Fuperal Service Ligens 22. Name and Address of Facility Barranco & Sons, P.A., 495 Gov. Ritchie Hwy. P.A., Severna Park Funeral Home Severna Park, MD 21146 floors that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, ceuse on each line. Immediate Cause (Final disease or condition julting in death) ANCE YEAR Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown AND PERITONEAL METASTAGE 24b. Wera autopsy findings available prior to 24e. Was an autopsy performed?

Physician Examiner

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page 2

director,

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Certification: To

Medical

29a. Cartifier

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this funeral

After

24 hours after death.

To the Vithin 2

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Department of Health and Mental Hy
Important: If flem 27 is marked oth-any injury or other traumatic event

Physician

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d Hygiene. other than "naturel", or Nerma 23a or 28a-f ahow vent, the Medical Examinat mant be notified at

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Baltimore, Maryland 21215-0020

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Records,

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The law requires

or Attending Physician:

Hospital

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical þ Completed

25. Wes cese referred to medical axaminer?

1 ☐ Yes

completion of cause of death?

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes

1 ☐ Yes 215 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 Pending investigation 1 atural 2 Acaident 8 Could not ba determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and Ittingol certif

29c. License number D29373

29d. Date signed (Month, Day, Year)

ERIC J. SEIFTER

10755 FAUS RO, SUITE 200 LUTHERNILLE MD 21093

State Registrar

31. Date filed (Month, Day, Year) MAR 0 9 2000





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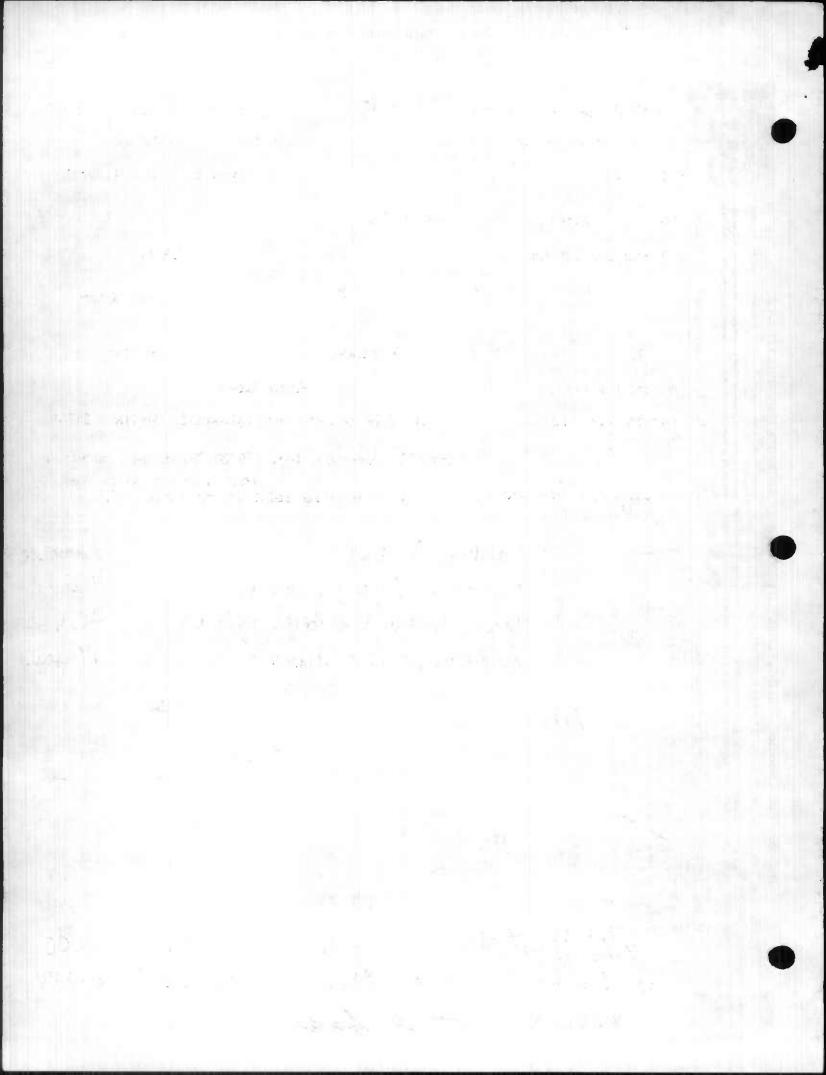
Amended Item #1, Per Phy., 03/06/2000, Carroll County, cew Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) Georgia Jeanette Cook 2. Date of Death 3. Time of Death Month **Physician** 4a Facility Name (If not institution, give street and number) 2000 6:16PM March /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) 5. Sociel Security Number 8. Date of Birth (Month, Dey, Yeer) **Funeral** 1□ M 2Ĭ F Months Days Hours Yrs. November 30,1919 California **Director** 551-12-2453 Usual Residence of Decedent the Meryland 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Directo Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21784 107 John Bennett Road U.S.A. permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Mexical Exercises than each. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 18 Mother's Name (First Middle Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Hazel Brown George Howenstein 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Carroll Cook/Husband 107 John Bennett Road Sykesville Maryland 21784 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carroll Cremation, Inc. 3/6/2000Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Jeffrey N. Zunbrun Funeral Home 21. Signeture of Funerel Service Licensee 6028 Sykesville Road Eldersburg, Maryland 21784 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ardiac Immodiate Examiner Examiner DIDIG and I-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 88 dise del VOICEDIA 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? page 2 s r this certificate h 2000 1 Yes 1 Yes 25 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 30 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ R/Outpetient 3 ☐ DOA 1 Yes within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner ss stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end little of certifie 6 30. Name end address of person who comp ted cause of death (Item 23a) (Type, Print) Georgetown Blod Elderburg 6190 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 6 2000

Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended 03/07/2000/#5/WCHD/MAP

1. Decedent's Name (First, Middle, Last) Reg. No. 2. Date of Death 3. Tima of Death Day Month Year **Physician** TEBRUARY 26 2000 ocation of Death 2345 **EDWARD** В. CORDREY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY 5. Social Security Mumber 8435 If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□F 217-14-85/4 82 Yrs. Director AUG. 25, 1917 MARYLAND Usual Residence of 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits 1 Yas 2 No Director 288-7 MARYLAND WICOMICO HEBRON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21830 27544 OCEAN GATEWAY U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hame 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2☑ Married 8 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 ASSISTANT MANAGER ICE CREAM CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Department of Health and Mental important: If Nem 27 is marked or any injury or other traumatic ave Pages 1 and 2 should be HERMUS C. CORDREY ETHEL SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) CORDREY - WIFE 27544 OCEAN GATEWAY PAULINE HEBRON, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removal from State SPRINGHILL MEMORY GARDENS 3/1/00 HEBRON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 705 E. MAIN ST. 22 Name and Address of Facility BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical pronary arter Examiner Examiner 45CVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician Physician/Medicai the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? No No 3 Probably 4 Unknown signed by Aprilio Valve Prosthesis 2 90 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24e. Was an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No this certificate director, Be 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending 1 Neturel To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mennar as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year)

State Registrar

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31. Date filed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registray's Signatura

CHRISTION HOSPLESTON M.D

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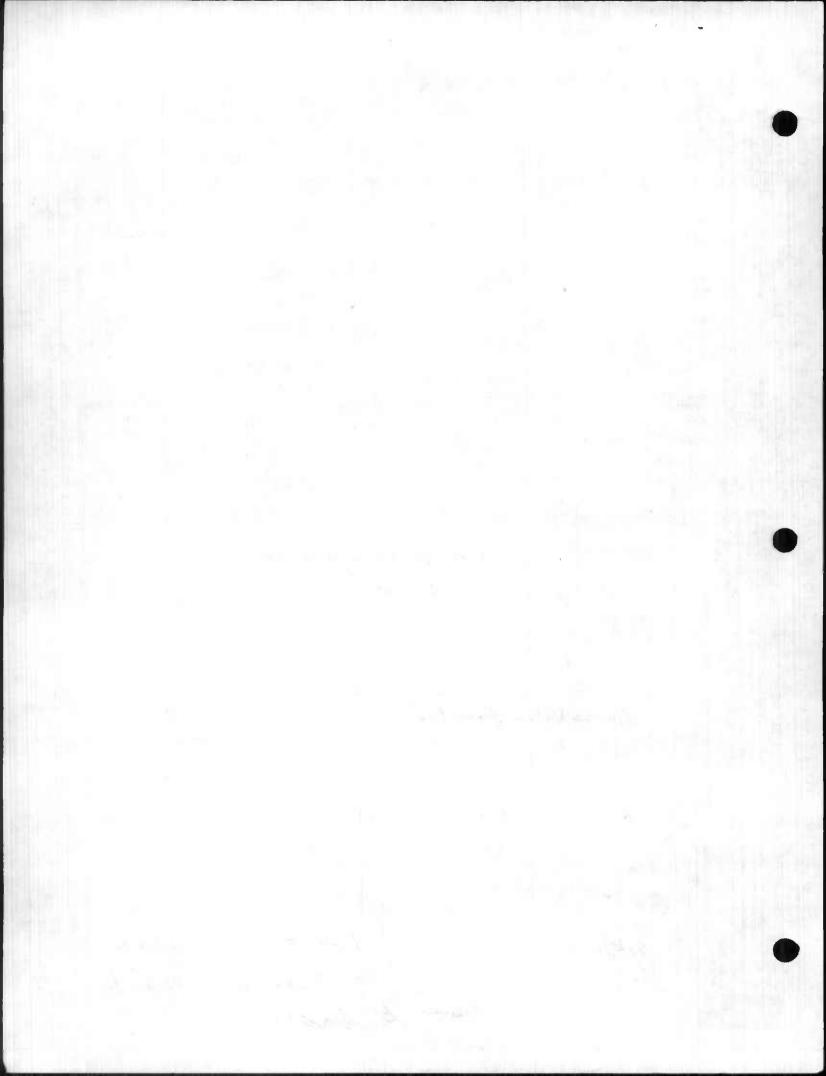
of Vital

Division

Attending Physician:

106 MILFORD ST.

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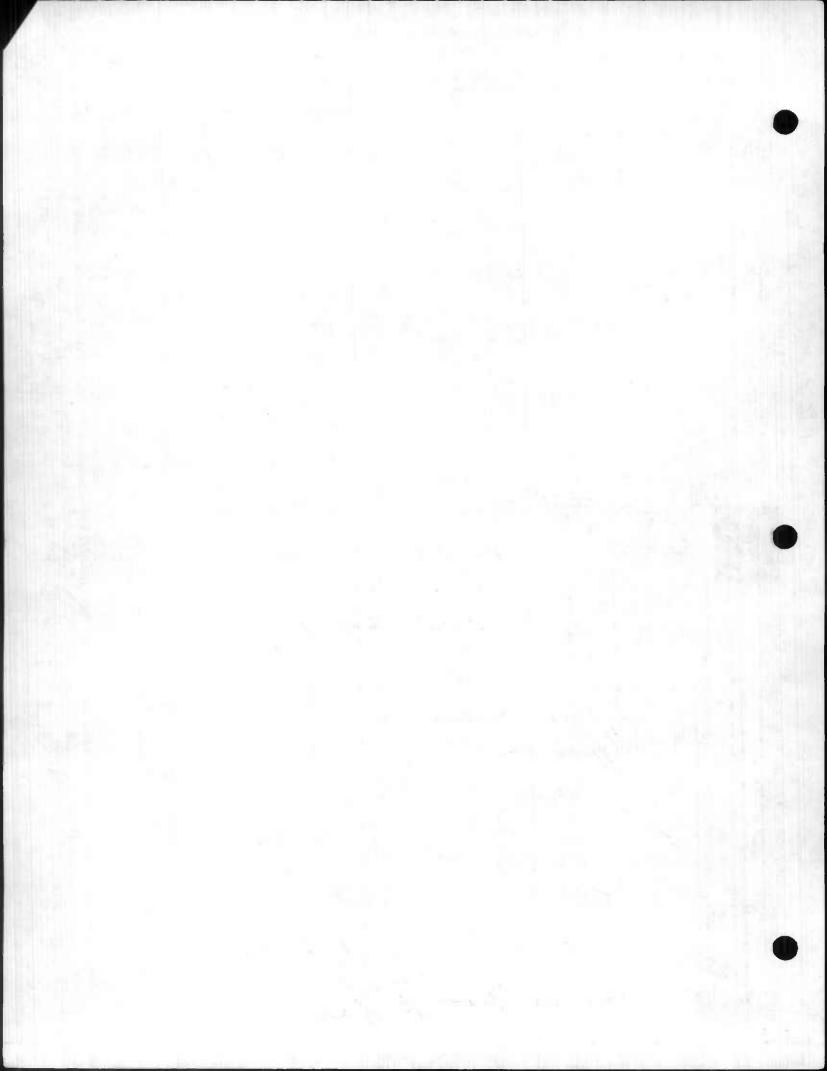
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1230 Clara M. Cropper 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF Days 228-36-8708 Director May 18, 1932 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show 1 Yes 2 No Funeral Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1804 Thomas Lane 21801 U.S. 14. Raca - American Indian, Biack, White, etc. Heme! 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 6 Black 1 ☐ Yes 2 No Specify Specify: py 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) 6th Poultry Inspector permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked eny injury or any injury or and injury or any injur Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Everett Clara Watkins 19e. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905-C Booth St., Salisbury, MD 21801 Shirley Wallace/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 3/11/00 Salisbury, MD Green Acres Mem Park 21. Signature of Europeral Service Linean 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner a The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Bud Box 68760. Physician/Medical Due to (or as a consequence of): for use es signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Unknown of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? funeral director, page 2 should 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 20 No certificate or Attending Physician: 25. Was case reterred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27, Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, atreet, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospitai 29e. Certifier 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. edicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) the 29d. Dete signed (Month, Day, Year) 29b. Signeture and title of certifier ran 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

Registrar

32. Registrar'a Signature

2000



Certificate of Death 1. Decedent's Nama prinsi, anddle, Last) 2. Date of Death Physician Month Year March 6 200 & ation of Death 4c. County of Death Mary Cooney Crossan /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY 222-24,1606 If Under 1 Yaar If Under 24 Hrs. Hours Min. Birthpiace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 XF Director 222-24-1600 6-1-1912 W. Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location Director 28a-f De. Sussex Laurel 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 8 23a Rt.#2 Box 207D 19956 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) or flams 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yas 2 🔀 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☐ No Specify: by 3 ☑ Widowed 4 ☐ Divorced Yaar or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) E. I. DuPont Co. Elementery/Secondary (0-12) College (1-4or 5+) Pigments Plant 12 Stenographer 17, Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit transit of Health and Mental H tant: If them 27 is marked oth jury or other traumatic even Be Charles W. Beard Pattie Hawthorne 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Mary Pat Taylor 6490 Riawakin Dr. Salisbury, MD 21801 20b. Place of Disposition (Name of cematery, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Brook Cem. 3-8-2000 Wilmington, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility 21. Signeture of Funeral Service Licensee Short Funeral Home avellan 13 E. Grove St. Delmar, DE 19940 Korn 23a. Part1. Enter the disaasa, or complications that day not the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on with line. **Physician** Xister enne /Medical Immediata Cause (Final disease or condition resulting in deeth) Examiner Examiner mus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the Due to (or as a consequence of): USB BS Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. been signed by the a should be detached 2∆ No þ

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of deeth? 2 No 1 Tas 1 ☐ Yas 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Nopatiant Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) Certification: To 1 Yas 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of fnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not ba 28e. Place of fnjury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 🖄 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29e. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

or Attending Physician: The law requires that the death certificate be assecuted Division of Vital Records, page 2 certificate funeral director. this After 24 hours after death.

Funeral Director: A filled in by Hospital completely within 2 To the I \$

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Registrar

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29b. Signatura and title of certified

29d. Date signed (Month, Day, Year)

SALISBUM

3. Time of Death

10d foside Cltv Limits 1 ☐ Yes 2X No

Approximate Interval Between Onsat and Death

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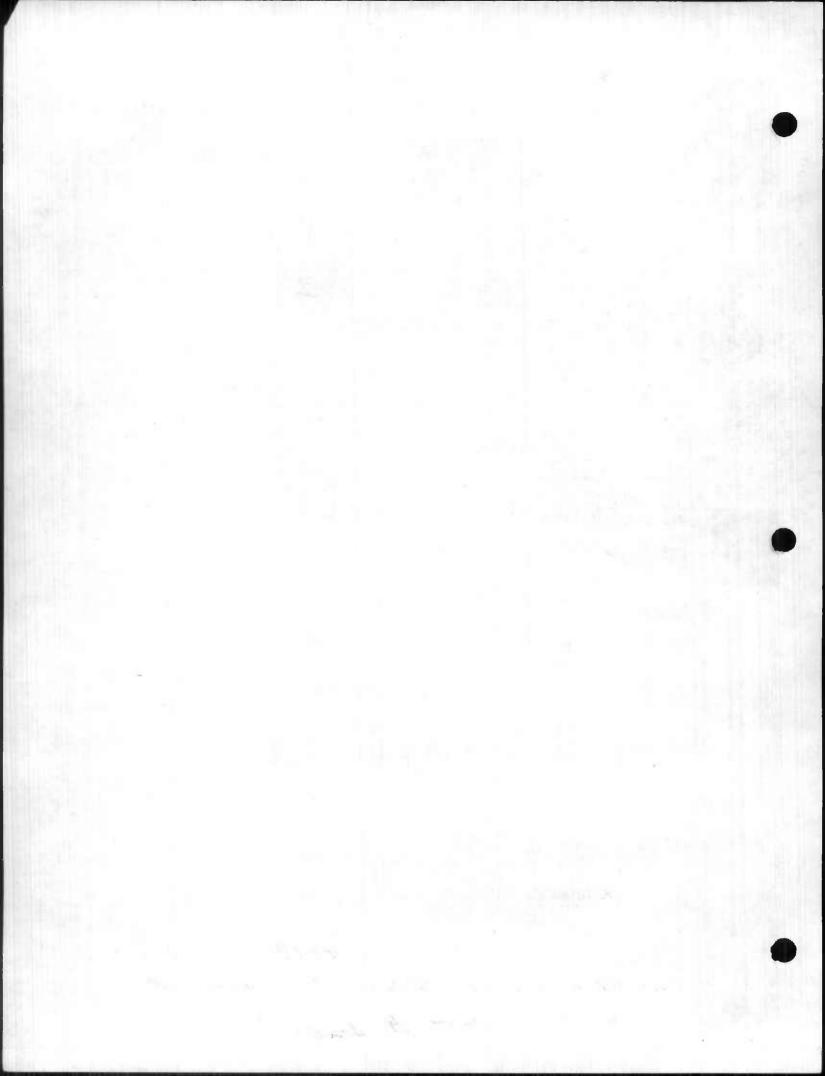
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30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

145 31. Data filed (Month, Day, Year) 32. Registrar's Signature

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29c. License number



Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

4 ☐ Homicide

29a. Certifier

220-12-34	424	110 M 2□ F	73	Yrs.	Months	Days	Hours	Min.	DEC. 1		6 VI	RGINIA
Usual Residence o	Decedent											
10a. State MARYLAND	10b. County WICOMIO	30	10c. City, Too	M or Local								10d. Inside City Limits 1 ☐ Yes 2 ☒ No
10e. Street and Nu		50	SAL			and a				10- 05-		2
Tue. Street and Nu	moer				10f. Zip C					iog. Citiza	en of What (
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11. Merital Status 1 Never Merr 3 Widowed	ied 2 Merned	12. Wes Decedent Armed Forces' 1 1 Yes 2 1 If Yes, Give Year or Dates:	No ARMY	HY	s Decede 'es, specif	y Cuba	ispanic Ori n, Mexicar Specify:	, Puerto	ecify Yes or No Rican, etc.)		4. Race - An Black, Wh Specify:	nerican Indien, nite, etc. WHITE
(Spec	15. Decedent's laify only highest g		160	(Give kin	nt's Usuel and of work NOT use	done o	during mos	t of work	ing	16b. Kin	d of Busines	ss/Industry
Elementary/Second 1 2	ondary (0-12)	College (1-4or	5+)	MINIS		1011100				ВАРТ	CIST /	RELIGION
17. Father's Name ALONZO		oper Oper						er's Nem RA	e (First, Middle A. DOD		iumeme)	
19a. Informent's N	eme/Reletionship	(Type, Print)	19	b. Meiling	Address (Street	and Numbe	er or Rui	ral Route Numb	er, City or	Town, Stete	, Zip Code)
NONA J.	COOPER -	WIFE		12 PH			DRRIS	DR.	SALIS	BURY,	MD 2	1804
		☐Removel from State	20b. Place cemen	ary, cremet	tory or oth	er plec	e) PARK		Dete 2/24/00			or Town, State , MARYLAND
21. Signature of Fu	Revit	D. Rym), CF 34				ss of Facilit				E. MAI	N ST., MD 21804
23a, Part1. Enter I shock, or hes Immediate Cause disease or condition resulting in death)	rt feilure. List onl (Final on	mplications that cause y one cause on each I	d the death. Do				g, such as			rrest.		Approximata Interval Between Onset and Deeth

COOPER

/Medical Examiner

> Certification: To Be Completed by Physician/Medical Examiner physician and s the burial-transit attending p 98 signed by the a certificata After this

The law requires that the death certificate be executed

To the Hospital or Attanding Physician:

within 24 hours after death. To the Funeral Director: A

2

filled in

completely

Medical

Division of Vital Records, P.O. Box 68760,

Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

nemonia

Due to (or es a consequence of):

Due to (or es a consequence of):

24a. Wes an autopsy performed?

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 tho 3 Probably 4 Unknown

1 Yes 2 No

2. Dete of Death

4b. City, Town, or Location of Death

SALISBURY

bray

Dev

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2000

WÍCOMICO

4c. County of Death

0245

9. Birthplece (State or Foreign

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No 1 ☐ Yes 27. Many for of Death 28d. Describe how injury occurred ADMINISTERED

28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No UNKNOWN POTASSIUM & KAYEXALATE 2 X Accident 2-21-00 6 Could not be determined 3 ☐ Suicide

28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) HOSPITAL

32. Regiever's Signature

28t. Location (Street and Number or Rural Route Number, City or Town, State) PENINSULA REGIONAL MEDICAL CENTER, SALISBURY, MD

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

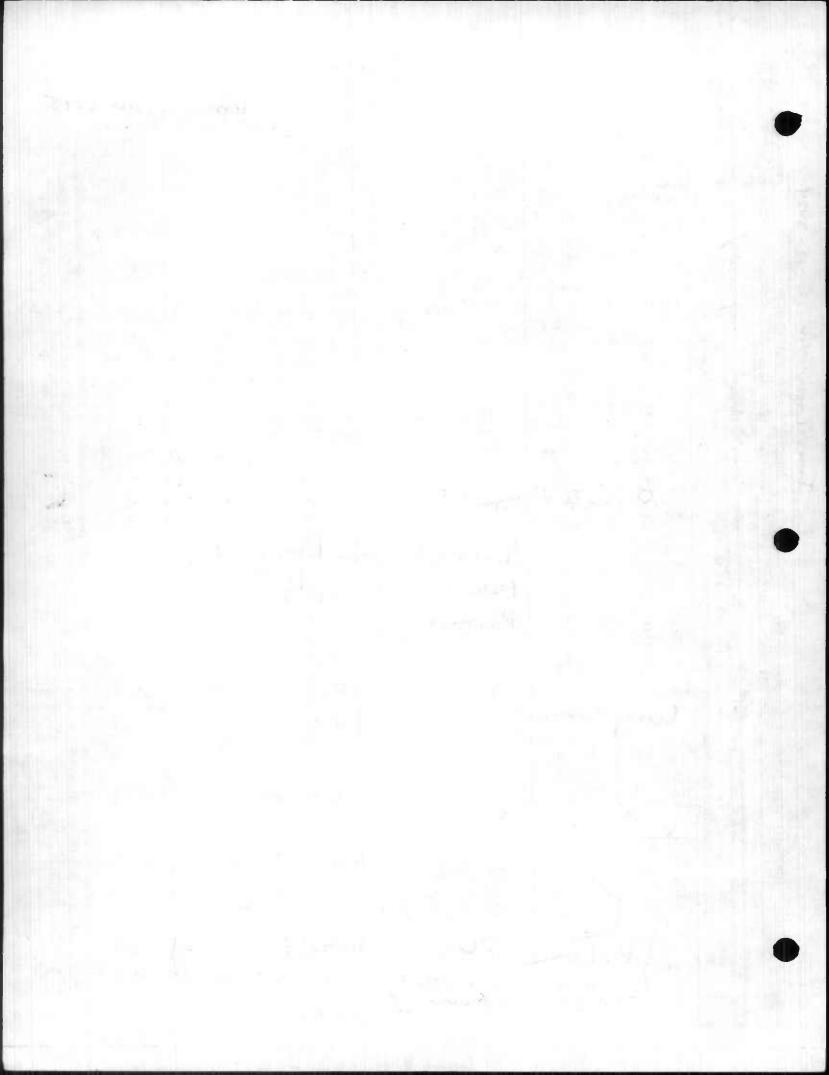
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who completed cause of death (Item 23a) (Type, Print) muscucie Granumi,

2000

MUFARD ST SUITE ZEL

State Registrar



Please Type or Print in Black Indelibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** -OLLINS 08:25 2 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** URALS SOMREBET ISLAND ANNE KR50 2988 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 12 M 20 F Yrs. 218-30 MAL Director 1414 Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Norma 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director SOMERSRY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21835 29882 15/AND DRH5 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, Whita, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Baltimore. Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: p 3 ₩ Widowed 4 Divorced - AMRRICAN RO Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mentel Hygiene. If Item 27 is marked other than Elementery/Secondary (0-12) College (1-4or 5+) 12 RPALMENT SUDEKVITCE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IZILAN Collins Collins DAGTER H. Collins MALIR 2 SR. 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAWATKER 32020 TERA LOWRL EDRN md. 20e. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete Date ery, cremetory or other place) 1 Dedrial 2 Cremetion 3 Removal from State ò Department of important: If eny injury or pace. WEST WELL CRIPKTAR 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility mo. DSABELLA 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** 00 /Medical Immediete Ceuse (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): attending for use as detached 23b. Did tobecco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1□ Yes 2/2(No 3 Probably 4 Unknown Division of Vital Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Menner of Death 28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Affer 1 DNetural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigetion 2 Accident n 24 hours after dea ne Funeral Director pletely filled in by th 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation in my origins, death occurred at the time date and the cause of the 29a. Certifier To the Hosp within 24 ho To the Fune completely fi Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 050 350 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) IT STIVA 31. Dete filed (Month, Dey, Year)
FEB 23

DHMH 16 Ray 6/95

State

Registrar

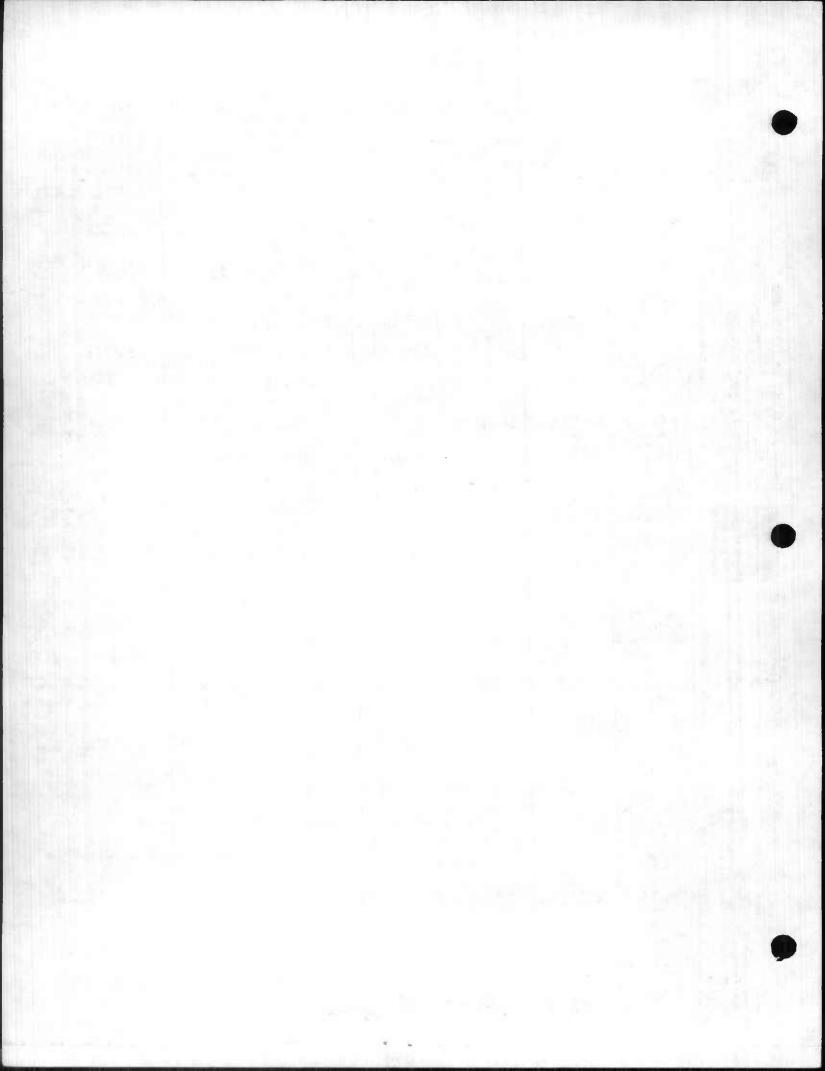
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32. Registrar's Signeture

2000

SAUS BURY



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Day Month Rushie March 2000 0345 9 4a Fscility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Union Hospital **Elkton** Cecil If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Months Days Hours 1□M 2XF Yrs 1908 Kentucky Oct 13, 290-18-1949 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No New Castle Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Sophia Drive 19702 TISA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) (no record of 1st name) Conley Lena Carpenter 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Arnold R. Toller - son 1074 Marl Pit Road, Middletown, DE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Cemetery 3/13/2000 Chillicothe, OH 21. Signeture of Funeral Service Licensee

Signeture of Funeral Service Licensee

Frank C. Mayer, Jr. 22. Name end Address of Facility Spicer Mullikin Funeral Home 1000 N. DuPont Hwy. New Castle, DE 19720 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting In deeth) acute respirata Due to (or es a consequence of) Streptocaced preumania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 M Unknown acute myocardial infarction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy small board obstriction 1 Yes 2 No 1 ☐ Yes 2 No cerebronarulo accident 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Examiner sician and burial-transit be executed Box 68760 P.O. Records, certificate Division of Vital this After

Examiner lan/Medicai 8 Physici þ Completed Be 2 funeral

Physician

/Medical

Examiner

DE

Director

Funeral

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Completed

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Funeral

Director

r than "natural", or flams 23e or 28e-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

5.2 should be filed within 7. In and Mental Hygiens. 7 is marked other than "na

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
important: If flem 27 is marked offix
any Injury or other transments of the

Physician /Medical

physician s signed by t or Attending Fafter death.

Director: After • Funeral C Hospital Medical npletely

within 2 To the State

Registrar

Keets Sever 10 30. Nama and address of parson who completed cause of death (item 23a) (Type, Print)

29b. Signature and title of certifier

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending

investigation

6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

28d. Describe how Injury occurred

00019043 - HD

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

3110100

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Kenneth Lewis, MDPA - 817 N. Broad Street, Middletown, DE

28b. Time of

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

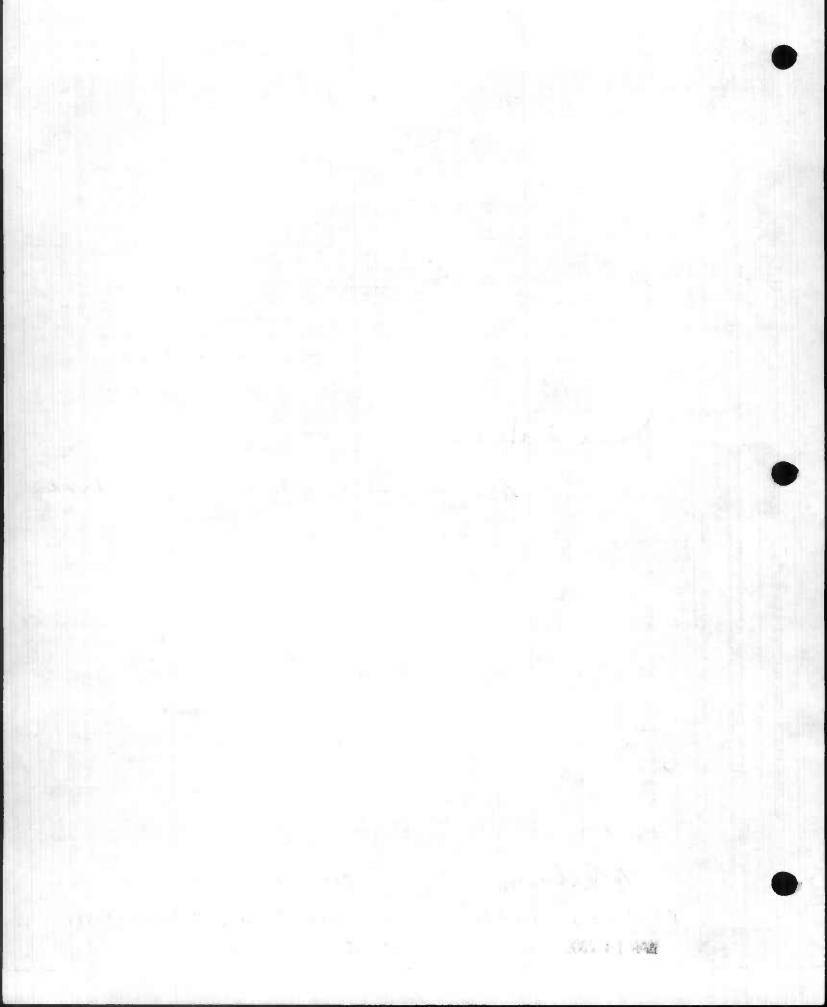
32. Registrar's Senature



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State of Maryland / Department of Health and Mental Hygiene

							Cei	rtifica	te of	Death		1	Reg. No.) (9090		
		1. De	cedent'a Neme (First,	Middle, La	st)							2. Date of Dec		Mana	3. Time of Death		
	Physician		Ilene Ba	ker P	helps (Cascio						Month	Day /2 , 2	Year	10:451	7	
	/Medical Examiner	4e E	acility Name (If not ins		- As					4b. City, To	wn, or Lo	ocation of Death			10,111		
-4	Examine	100	FO Diebe	1 D.						77.7.1-	L		000	-17			
-	F-100-1	5. So	50 Richa cial Security Number	fa Dr		7. Age (In vrs	. last birthday)	If Unde	r 1 Year	Elk:		8. Dete of Birt	h	9 Birtho	place (State or Foreig	an	
	Funeral Director				□M 2/√ F	56	Yrs.	Months	Days	Hours	Min.	(Month, Da	, Year)	1	place (State or Foreigntry)		
Ш			6-66-6238 t Residence of Deced	ent	-	30					l	FEB 2,	1944	West	Virginia		
	and with	10a.				10c. C	ity, Town or Lo	cation						1	10d. Inside City Limit	ls	
	Aary or	Ма	ryland	Ce	cil		Elkton								1 ☑ Yes 2 □ N	lo	
	or 28s-1s be notified	100	Street and Number						- Codo				10= Chines of	Min at Cau	-12		
	Di ye	100.	Street and Number					101. 21	p Code				10g. Citizen of	What Coul	ntry r		
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	r hams 23	11. M	eritel Status		12. Was De Armed F	cedent Ever in torces?	J,S. 13. \	Wes Dece	dent of F	fispanic Ori an, Mexicar	igin? (Sp	ecity Yes or No- Rican, etc.)		ce - Americ ck, White,	can Indian, . etc.		
0	filed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or items 23a or 28a-1 show brit, the Medical Examine must be notified at 8. Completed by Funeral Director	1	Never Merried 2	Merried		2 No		1 🗆 Yes	111	Specify:				y: Whi			
21215-0020	"natural", or	3	☐ Widowed 4次 Div	vorced	Year or	Dates:		A). WIII	rce		
5-0	ed within 72 ho ygiene. Wer then "neture It, It - Western Completed		15. De	cedent's Ed	ducation de completed	n	16a. Deced			pation 16b. Kind of Businass/Industry during most of working					dustry		
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21	Noise To	5	11			(H	Iomem	aker				In her	own	home		
b	be file d othe svent,		ather's Neme (First, M	fiddle, Last,):					18. Mothe	er's Name	a (First, Middle,	Maiden Sumai	ne)			
lar	Menta Menta arked arked		Guy Virgi	l Bak	er			Leona Reedy									
Maryland	and Mental is a marked of wmetic ave		Informent's Neme/Rel	-			19b. Meilir	na Addres	s (Street			al Route Numbe	or, City or Town	. State, Zir	p Code)		
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altimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than any injury or other traumatic avent, if a Monce. To Be Compl	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete cemetery, cremetory or other place)											ony or the				
E	men	4 Donation 5 Other (Specify) Cherry Hill Methodist Cem. 3/15/0 Cherry H: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility												y Hil	l, Maryla	nd	
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v	Physician // // // // // // // // // // // // //	Immediate Cause (Final disease or condition resulting in death) a. Advancur(noma Small Bornel									1	11					
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	that the death certificate be executed or by the attending physician and detached for use as the burial-transit y Physician/Medical Examir	Sequ	entially list conditions			Due to (or es a conseq	luence of)	:								
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of Vital Record	certificate rector, pag	25. W	as casa refarred to m	nedical						26. Place	of Deat	th (Check only o	na)				
2		1	kaminer? ☐ Yes 2K No		Hospital:	Inpatient 2] ER/Outpatien	nt 3[] D	OA Ott	ner: 4 Nu	ursing Ho	ome 5 ARasio	ience 6 100t	her (Speci	myDaughter	s	
	Ming Physics After this funeral di		anner of Death		28a. Date	of Injury oth, Day Year)	28b. Tima of	1	28c. Inju			28d. Describe I			Residence		
0	After	11		Pending nvestigation		nin, Day Year)	Injury	м		Yes 2	No						
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5	or long	4	Homicide	Jetamineu	buik	ding, etc. (Speci	ity)		,,			City or To	vn, State)				
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	4	30. N	ame and addrass of p	erson who	completed cau	use of death (tte	m 23a) (Type,	Print)	-	1							
		30. Name and addrass of person who completed cause of death (term 23a) (Type, Print) If Furl 2ss, np VNA Worthern Che supeake Hospice, Elkton, np 21921															
	State	31. D	ate filed (Month, Day,	Year)	32.	Registrar's Sign	ature	1	-	,	N'		1/				
	Registrar		MAR 14 2	2000	Sens	va ,	O. A.	DOLL	2								



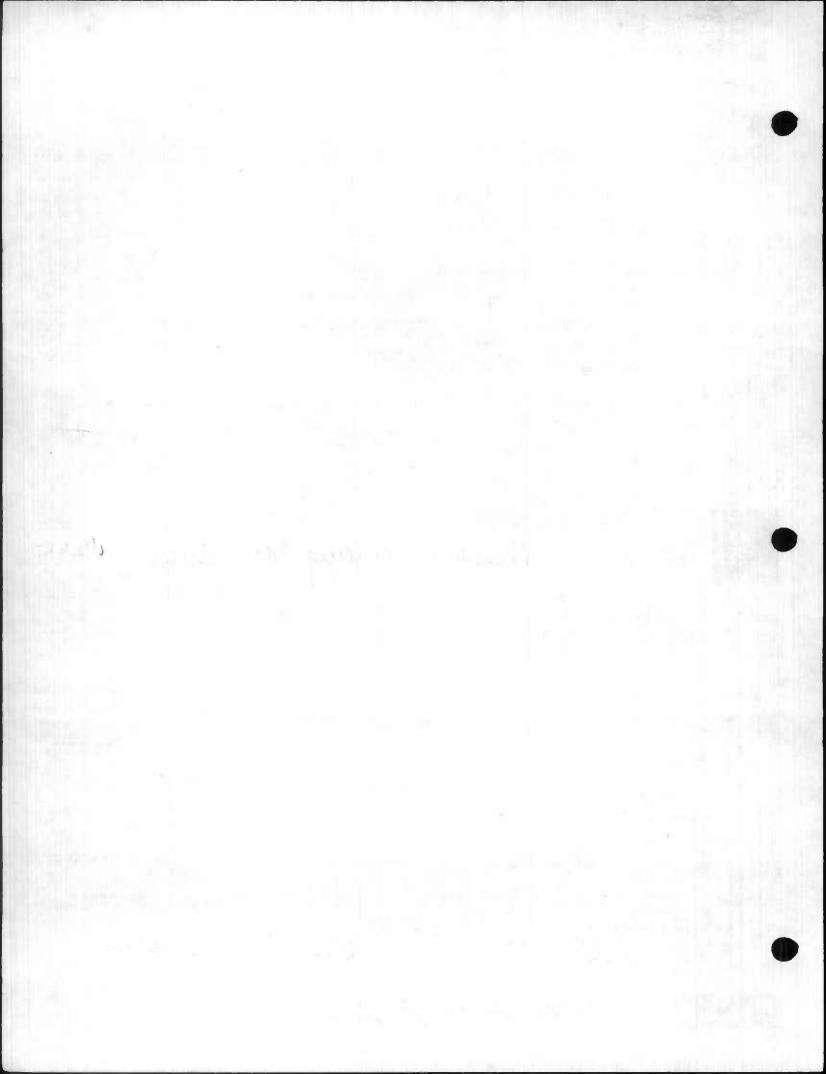
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Joan Coccaro 13, March 2000 0325 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Memorial Hospital Easton Talbot If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days 1 ☐ M 2 🖾 F Director 070-34-8752 57 Oct 22,1942 New York Usual Residence of Decedent the Maryland 10a. State 10b Counts 10c. City, Town or Location show 10d, Inside City Limits 1 Yas 2 No Directo 280-0 Maryland Talbot St Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 'natural', or hams 23a Funeral 206 Lincoln Ave 21663 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Yes, Give Year or Dates: 1☑ Never Married 2☐ Married 21215-0020 1 Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ nurse diploma nursing educa. mit. Pages 1 and 2 should be filed seriment of Health and Mental Hyg certant; if Item 27 is marked other injury or other traumatic event, altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Frank Coccaro Jennie Tomasino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Lincoln Ave St Michaels, Maryland Jennie Coccaro/ mother 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 15,2000 Greensboro, Maryland 21. Signature of Funnial Service Licenses 22. Name and Address of Facility Fleegle & Helfenbein Funeral Home PA lu PO Box 160 Greensboro, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician Ensural Cell leng Corcerique 11/24KJ /Medical Immediate Cause (Final disease or condition resulting in death) Examine Examiner physician and the burief-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the rather should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? Pege 2 1 Yes 2 No 1 Yas 2 No certificate Division of Vital ial or Attending Physicien: The after deeth.

It Director: After this certificated in by the funeral director, pr 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Maryrier of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ed in by 4 Homicide within 24 hours a To the Funeral D completely filed Hospita 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical ŝ 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3113 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29466 Pintail Drive Easton, MD 21601 David Smith, MD 31. Date filed (Month Pay Year) MAR 1 4 2000 32. Registrar's Signature State Registrar

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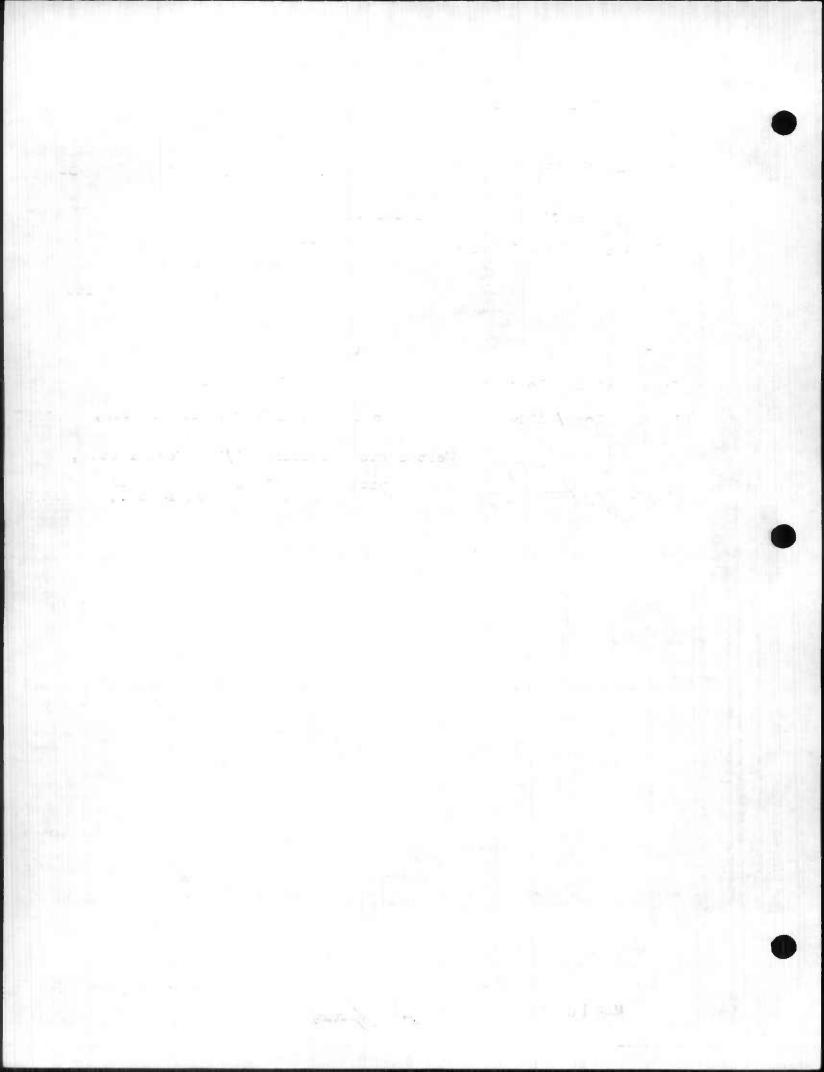


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State of Maryland / Department of Health and Mental Hygiene

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Henry William					2. Date of Dea Month					
do Facility Name III and Incide ston about the	Close				1000					
4a Facility Nama (If not institution, giva s	street and number)				Location of Death	4c. County of	of Death			
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5. Social Security Number 6. Sex 217-92-0952	57 -	n yrs. last birth	Months D	ear If Under 24 Hrs ays Hours Min		Year) 2 1965	9. Birthplace (Stata or Foreig Country) DC			
10a. Stata 10b. County	10	c. City, Town	or Location				10d. Inside City Limits			
MD Carroll	Service I	Wes	tminste	r			i Yes 2 □ No			
10e. Street and Number			10f. Zip Co	de	1	0g. Citizen of W				
65½ South Colon	nial Aven	ue		21157		U	SA			
MD Carroll 10e. Street and Number 65½ South Colon 11. Marital Status 1□ Nevar Married 2월 Married 3□Widowed 4□Divorced	12. Was Decedent Eva Armed Forces? 1 Yas 2 No if Yas, Giva Year or Datas:	r in U,S.		of Hispanic Origin? (S Cuban, Mexican, Puer (No Specify:	Specify Yes or No- to Rican, etc.)	res or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
	cation	16a. C	Decedent's Usual O	ccupation		16b. Kind of Business/Industry				
15. Decedant's Educ (Specify only highest grade Elementary/Secondary (0-12) 1.2	Cottega (1-4or 5+)		Give kind of work d lifa. DO NOT use n	ccupation one during most of wo stired)	orking					
12	ga (1 401 01)	C	arpente	r		Unknow	rn			
17. Fathar's Nama (First, Middle, Last)				18. Mother's Na	ma (First, Middle, i	Maiden Surname	s)			
James Calvin Cl	Lose Sr			Helen	Maske					
19a. Informant's Name/Ralationship (Typ	pe, Print)			treet and Number or R						
Claudia Close/Wi	ife	65	South	Colonial	. Ave We	stmins	ter, MD 2115			
20a. Mathod of Disposition		20b. Place of I	Disposition (Name of crematory or other	place)	Date	20c. Location - 0	City or Town, State			
1 ☐ Burial 2 ☐ Cramation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stata			Cemetery	3/13	Westmi	inster, MD			
21. Signature of Fungual Service Ligansee	10		22. Nama and A	ddrass of Facility						
		_		Funeral shington						
23a. Pal11. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the	death. Do no					Approximate Interval Between			
Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in daath) Last		a to (or as a co	nsequence of):							
that initiated events	Due	to (or as e co	nsequence of):							
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		ot resulting in t	the underlying caus	e given in Part I.			tribute to the cause of death			
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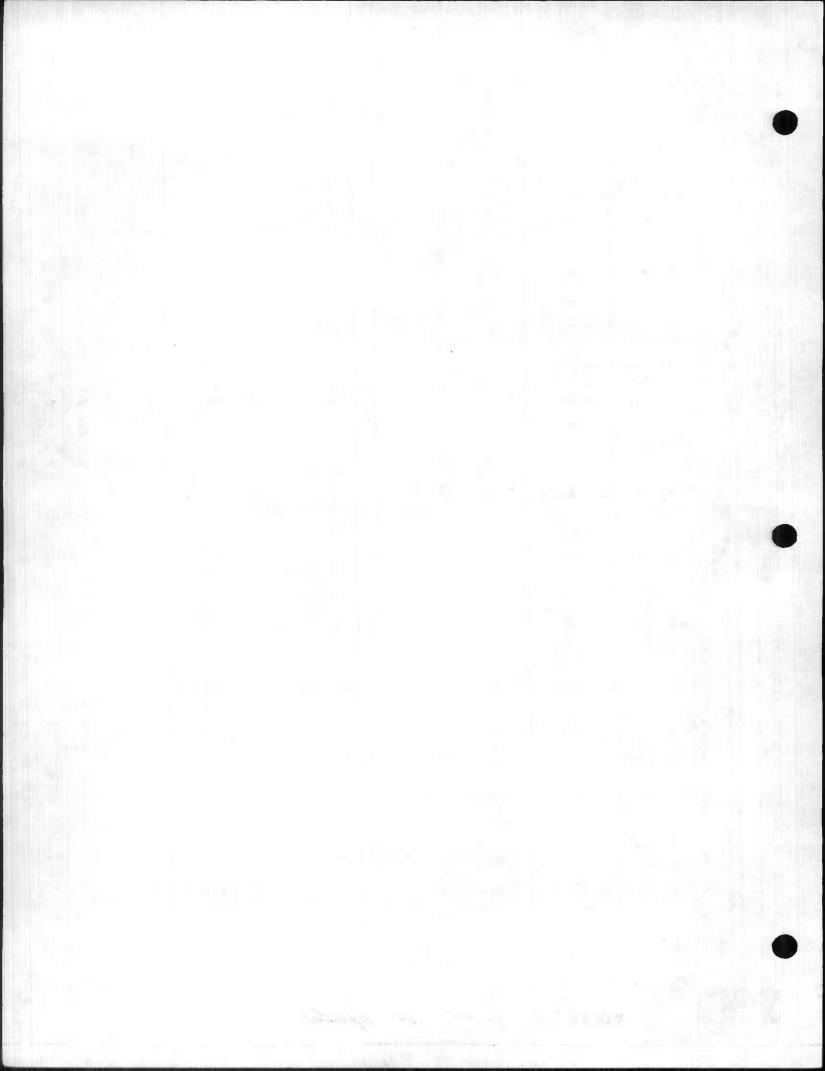


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1915 March man 2000 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Niversity al Security Number Ba Himore 7. Age (In yrs. last birthday) of Hunder 24 Hrs. 8. Dete of Birth (Month, Pay, Year)

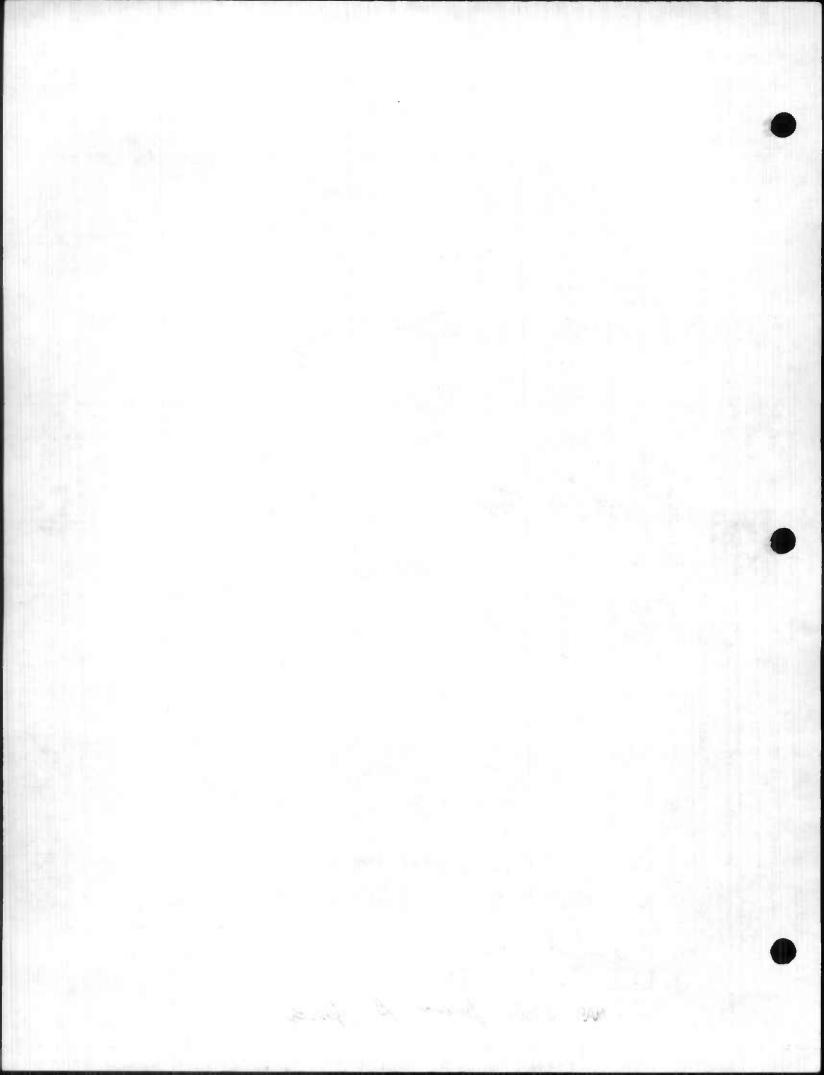
July 1, 1914 If Under 1 Year 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2 F Mar Vland 212-38-0258 85 Vrs Director Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 U.S.A. 1914 Brick Church Rd. death , Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. permit. Peges 1 end 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or fee may injury or other traumatic event, the Medical Examinations. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: p 3 Widowed 4 Divorced White Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) seamstress clothing factory 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Walter Baltzell Edith Frances Adams 10 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Curfman/ husband 1914 Brick Church Rd. New Windsor, MD 21776 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ₺ Buriel 2 □ Cremetion 3 □ Removel from State Linganore Cemetery 3/6/00 Unionville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Hartzler Funeral Home 21. Signature of Fune al Service Licenses 310 Church St. New Windsor, MD 21776 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner siclen end buriel-transit or Attending Physician: The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760, physiclen s the burie Due to (or as a consequence of): use as igned by the e Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown Records. þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital funeral director. Be 25. Wes case referred to medical axeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier completely (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of oprtifie 30. Name and address of person who completed/cause of death (Item 23a) (Type, Print) Baltimore Street L. Wright mis 22 Wendy South reene 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 8 2000

DHMH 16 Rav 6/95



				epartment of Certificate o			Reg. No.	0 09600			
hysician	Decedent's Nema (First, Middle, L Virginia Juanit		Juani	ta V. Cox)		2. Data of De Month	Day	Yaar 3. Time of Dea			
/Medical Examiner	4a Facility Nama (If not institution, gi				4b. City, Town, or	MARCH Location of Deat	9, 20 h 4c. County				
	2 B STREET				LOTHIAN		ANNE	ARUNDEL			
	228 52 5874	Sax 1□ M 21X F 63	yrs. last birth	hday) If Under 1 Yes Months Dey			th by. Year) 7, 1936	9. Birthplace (State or Fo			
tor	Usual Rasidence of Decedent 10a. State		City, Town					10d. Inside City Li 1 ☐ Yas 2/C			
Funeral Director	#2 B Street, L	yons Creek M.	H. Est	ts. 2	0711		10g. Citizen of What Country? USA				
1	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates:	in U,S.	13. Was Decedent of It Yas, specify Cu		5,000,000					
	15. Decedent's E (Specify only highest gi Elementery/Secondary (0-12)	Education rade completed) College (1-4or 5+)		Decedent's Usual Occ (Give kind of work don life. DO NOT use reti afeteria W		orking		ic schools			
To Be C	17. Fathar's Nama (First, Middla, Las Dave	Bled	lsoe		18. Mother's Na Mary	me (First, Middle	, Maiden Suman	Cole			
	19a. Intormant's Name/Ralationship Dwayne Allen Cox			Mailing Addrass (Stre 2408 Fitze							
	Dwayne Allen Cox (son) 22408 Fitzgerald Dr., Gaithersburg, MD 20a. Method of Disposition **TXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Maryland Veterans Cem. 3-13-00 Cheltenha										
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736										
	M. Mela	Magn						20/36			
	23s. Part1. Enter the disaase, or cor shock, or haart tailure. List only	v one cause of each line.			yrig, such as cardie	ac or respiratory a	rrest,	Approximata			
	Immediata Causa (Final disease or condition resulting in death)	CORONARY A	KIERY T	HROMPOSIS	ying, such as cardie	ac or respiratory a	irrest,	Approximata Intervel Between Onset and Deat			
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Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disease or Injury that initiated events resulting in death) Last Part tt. Other eignificant conditiona 25. Wes casa raterred to medical examinar?	a. CORONARY A Due b. ARIFRIOSCI Dua c. Dua d. Contributing to death but no	to (or as a co	IHROPOSIS onsequence of): CARDIOVASCUL onsequence of): tha underlying causa	AR DISEASE given in Part I. 26. Place of De	23b. Dfd 1 □ 24a. Was perfi	tobacco use co Yea 2□ No san autopsy ormed? Yes 2□ No one)	ontributa to the cause of de 3 Probably 4 Unit available prior to completion of caus of death?			
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To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Disaase or Injury that initiated events resulting in death) Last Part tl. Other eignificant conditiona 25. Wes casa raterred to medical examinar? XIX yes 2 No 27. Mannar of Death 1 Natural 5 Pending Investigatic all Suicide 6 Could not determined.	a. Due ARIFRIOSCI Dua c. Due d	to (or as a control of the control o	CARDIOVASOUL consequence of): characteristic consequence of): tha underlying causa of the underlying	AR DISEASE given in Part I. 26. Place of De Other: 4 Nursing jury at Jork? Yas 2 No	23b. Dfd 1 24a. Was perfil 24a. Was perfil 28d. Describe 28d. Describe 28t. Location City or To	tobecco use co	Intervel Between Onset and Deat Onset Onse			



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Physic	ian	1. Decedent's Name (First, Middle Lorraine H.	(Last) Christop	har				2. Date of Do Month	Day \	3. Tima of Dea		
/Medi	cal	4a. Facility Nama (If not institution,	-				4b. City, Town, or	March Location of Deat	6 2000 th 4c. County of			
Exami	ner	1700 Golden Cou	· ·	,			Crofto			Arundel		
Funeral Director		5. Social Security Number 577 38 6163	6. Sex 7. A	ige (In yrs. 68	last birthday) Yrs.	If Under 1 Ye Months Day			rth ay, Year) , 1931 W	9. Birthplaca (State or For Country) Tashington D		
M to		Usual Residence of Decedent 10a. Stata 10b. County		10c. Ch	ty, Town or Loc	eation				10d. fnside City Lii		
Hedi	tor	Maryland Anne A	rundel		Crofton	ı				1 ☐ Yes ఈ⊠		
or 28	Direc	10e. Street and Number 1700 Golden Cou				10f. Zip Code			10g. Citizen of Wh			
23	erai	11. Marital Status	12. Was Decedan	t Ever in I	10 12 14	les Dosedent s	21114		United S			
Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic event, the Medical Exercises must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	No	If	Yas, specify C	f Hispanic Origin? (suban, Mexican, Puer Jo Specify:	to Rican, etc.)	No- 14. Race - American Indian, Black, White, atc. Specify: White			
lesi E	pete	15. Decedent' (Specify only highes			16a. Deced	ent's Usual Occ	ness/Industry					
Pan -	Be Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		pedent's Usual Occupation a kind of work done during most of working DONOT use retired) Pmaker Own Home						
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ked of	Charles H:		lilton				Edit					
19a. Informant's Name/Relationship (ip (Type, Print)		19b. Maliin	g Addrass (Stre	et and Number or R	tate, Zip Code)					
Donald J. Christo			topher Hus	sband		Golden	Court Cro	ofton Maryland 21114				
If Hen		20a. Method of Disposition 1 □ Buriai 2 ☒️Xremation	3 □Removal from State		Place of Dispos cematery, crem	ition (Name of atory or other p	niace)	Date	20c. Location - C			
4 Donation 5 Other (4 Donation 5 Other (Sp	ecity)	H		ematory		3/8/99	Waldorf,	MD		
Depa impo any tr		21. Signature of Funeral Service L	1 PI	/_					Home, Inc.			
		23a. Part1. Enter the disease, or shock, or heart failure. List of	· Up	el (h Do not ente	5000 An	napolis R	d.Bowie	Maryland	20715 Approximate		
Medical caminer ফু	Examiner	Immediata Cause (Final disease or condition rasulting In death)	a. 50		or as a consequ		cer			11 Mon		
ding physician and se as the burial-transit	edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last	c		or as a consequ							
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igned by the a be detached f	by Physician/M	Part II. Other significant condition	s contributing to death	but not res	sulting in the un	derlying cause	tying cause given in Part I. 23b. Dfd tobacco use contribute to 1 Yes 2 No 3 Prot					
peen	Completed b							24a. Was	s an autopsy ormed?	24b. Were autopsy findir available prior to completion of cause of death?		
page 2	Con							10	Yes 2□No	1 ☐ Yes 2 ☐ No		
s certificate director, pay	Be	25. Was casa referred to medical examiner?	Hospital:				Whee	ath (Check only				
ter this neral di	tion: To	1 Yes 20046 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Num						1	idence 8 Other how injury occurred			
s effer death. I Director: Af ed in by the fu	Certification:	2 Accident investigi 3 Sulcide 6 Could n 4 Homicide determin	ot be 28e. Place of Ir	ijury - At h tc. (Specif		et, factory, offic		28f. Location City or To	(Street and Number own, State)	or Rural Route Number,		
within 24 hours efte To the Funeral Dir completely filled in	edicai (29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis of and manner s	of axamina	wledge, death ition and/or inve	occurred at the estigation, in m	time, date and plac y oplnion, death occ	e, and due to the urred at the time,	cause(s) and mann , date and place, an	ner as stated. d due to the cause(s)		
within 2 To the comple	Me	29b. Signature and title of certifier					onse number			(Month, Day, Year)		
3 F 0	29D. Signature and title of certifier			1.D.		D 39505 March				6.2-000		
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State of Maryland / Department of Health and Mental Hygiene 09602. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** W. Marguerite Coates 2000 9:15PM March /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 7241 Joplin Street Seat Pleasant Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | Oct. 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2ਊF 579-26-6495 80 Yrs. 1919 Georgia Director Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Prince George's Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7241 Joplin St. 20743 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Detes: 11. Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours after-Hyglens. other than "natural", or ite 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: p 34 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Employee i. Pages 1 and 2 should be filed wi tment of Health and Mental Hyglen tant: If item 27 is marked other th ijury or other trsummatic event, the Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Ross Effie Mae Driver 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gardenia P. Hill - Neighbor 7239 Joplin St., Seat Pleasant, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If eny Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 3/10/2000 Harmony Memorial Cem. Landover, MD 22. Name and Address of Facility 21. Signature of Funerel Service Licenses Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Uvm Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel CARCINOMA diseese or condition resulting in death) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760, Due to (or as a consequence of): USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? page 2 2 X No certificate 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 89 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Daturet To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 5 Pending 1 Yes 2 No 2 ☐ Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Types Brint). (If Road; # 220; Bourg-MD-20716 31. Dete filed (Month, Day, Year) 32 Registrar's Signeture State

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Registrar

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DIVISION OF VITAL

TENDING PH	JARECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should now with the State Dear, of Health and Mental Hydiene prior to bunial, cremation, or removal.	PORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
G PH	TO THE FUNERAL DIRECTOR: After this ce he filed within 72 hours after death with the	IMPORTANT: If item 28 is marked

	1 - STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND N	MENTAL HYGIEN	E			
	t. DECEDENT'S NAME (Flist, Middle Marv	Catherine Corn			2. DATE OF DEATH MONTH MArch 3,	2000 YE	3. TIME OF DEATH 0345 M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday) IF U	NDER 1 YEAR IF UNDER 24 HRS. HB DAYS HOURS MIN.	7. DATE OF BIRTH	8. 1	BIRTHPLACE (State or Foreign County) ashington DC		
	579 26 0062 se. FACILITY NAME (If not institution	4343	12	CITY, TOWN OR LOCATION OF DE	May 6, 19	9c. COUNTY			
TOR	Southern Maryl	and Hospital		Clinton		Princ	e George's		
DIRECTOR	10a. STATE 10b.	P.G.		on Location Springs		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
	100. STREET AND NUMBER			10f. ZIP CODE			ZEN OF WHAT COUNTRY?		
FUNERAL	6309 Joyce	Drive	NIIS ADMED	20748 13. WAS DECENDENT OF HISPAN	IIC OBIOINS (Parally Van		d States RACE — American Indian,		
B⊀	1 Never Married 2 X Marrie 3 Widowed 4 Divorced	CODOCCO 4 VEC		If yes, specify Cuben, Maxical 1 YES 2 NO Specify	n, Puarto Rican, atc.)	14.	Bleck, White, etc. Specify: White		
TED	15. DECEDENT (Specify only highe	r'S EDUCATION st grade completed)	16a. DECEDENT'S USUA (Give kind of work of	one during most of working	16b. KIND OF BUS	SINESS/INDUST	FIY		
COMPLETED	Elementary/Secondary (0-12) 12	College (1-4 or 5+) 2	Retired St		Bell At	lantic	:		
S	17. FATHER'S NAME (First, Middle, I				ME (First, Middle, Maiden	Sumame)			
BE	19a. INFORMANT'S NAME (Type/Pri		19h MAILING ADDI	Glady RESS (Street and Number or Rural F	s Baker	n State 7in Co.	441		
2		Cornwell/Husba							
	20a. METHOD OF DISPOSITION	200	D. PLACE AND DATE OF DIS	POSITION (Name of March	8,04200 Boc. LO	CATION — City	or Town, State		
	4 ☐ Donetton S ☐ Other (Special Street Special Street Special Street Special Street Special Special Street Special Street Special Street Special Special Street Special Speci	MF.	ryland Vet	<u>erans Cemetery</u>			m, Maryland		
	1	() / H	M01095	22. NAME AND ADDRESS OF FA					
	23. PARTY I. Enter the disease ahock, or heert f	ellur List only one ceuse on e	d the death. Do not e	nter the mode of dying, auc	h as cardiac or respi	ratory arrest			
	immediate cause (Final disease or condition resulting in death)	.CHRON	ic Pu	IMONAL					
z		ATHERO	SCUER	oic HE	IRT DI	SEA	192		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF):	CER DI	CEAC	C			
FIC	CAUSE (Disesse or injury that initiated events	C. DUE TO (OR AS	A CONSEQUENCE OF):	CAST DI	1000				
ERT	resulting in death) LAST	d							
AL CI	PART II. Other significent co	nditions contributing to deeth i	out not reaulting in the	e underlying cause given in			24b. WERE AUTOPSY FINDINGS		
SICA	KENAL	- INSU	CPIC'S	EMCA	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
ME	ARTH	RITIS					1 TES 2 NO		
AN:	DID TOBACCO USE C	CONTRIBUTE TO CAUSE C	26. PLACE OF DEATH (C)		N 🔲				
SICI	EXAMINER? 1 YES 2 NO	HOSPITAL:	ОТ	HER: Nursing Home 5 - Residence	8 ☐ Other (Specify)				
PHYSICIAN: MEDIC	27 MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCUR	ED		
) BY		Igation 28e PLACE OF INJUST	Y — A1 home, ferm, street	M 1 YES 2 NO	28f. LOCATION (Street	and Number or I	Rural Route Number,		
ETEI	4 Homicide datem		City)		City or Town, State)				
COMPLETED	CONSCR UNITY Z ZZ	G PHYSICIAN: To the beat of my know EXAMINER: On the beats of exeminate			, .		suse(a) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF C	50mm	m	29c LICENSE NUI	MBER 7744		gned (Month, Day, Year) rch 4, 2000		
2	30 NAME AND ADDRESS OF PER	SON WHO COMPLETED CAUSE OF DE	EATH (ITEM 20 (Typo Synt	PISCA	TANA	4	SO CLINEN		
	31. DATE FILED (Month, Day, Year) MAR 0 7 20	32 REGISTRAR'S SIGI		de					
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Physician /Medical Examiner physician and the buriel-transit

68760 Box P.O. Records. of Vital Division or Attanding To the Hospital of within 24 hours a To the Funeral C completely filled

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Deeth March Physician 3:25 AN 2000 Caroline Bertha Cheseldine /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Davs 1 M 2 X F 363-20-7422 78 Feb. 21, 1922 Director Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No Director Maryland Prince George's Berwyn Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23s or 5604 Seminole Street 20740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 XNo If Yes, Give Year or Dates: 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) .11. Marital Status Black, Whita, atc. 1 Never Merried 2 Married Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 7, and Mental Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Inspector Fairchild Industry 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file transported to the part of the part Louis Holecek Katherine Forijt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Bernard Cheseldine - Husband 5604 Seminole Street, Berwyn Heights, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Steta Important: If It 1 Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 3/10/2000 Parklawn Cemetery Rockville, Maryland nature of Funeral Service Libenses 22. Name and Address of Fecility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 234. Part. Enter the disparent or complications that caused the detail. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hour failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) · CHRONIC OBSTRUCTIVE DULHONARY DISEASE. To years Due to (or as a consequence of): Examiner VEIN THROMBOSIS werks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): MELLITUS DIABETES Physician/Medical 2 WEEKS Due to (or as a consequence of): AZOTAENIA morn 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown b 24b. Were eutopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only one) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Netural
2 Accident 5 Pending investigation after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 I Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0013668 3-7-00 EX P. DATE . 9-30-00 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) MD. 4917 EDGEWOOD RD. COLLEGE PK. MP. 20740. AZHER HUSSAIN 31. Dete filed (Month, Day, Year) 32. Begistrar's Signature State Registrar MAR 0 9 2000

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State of Maryland / Department of Health and Mental Hygiene

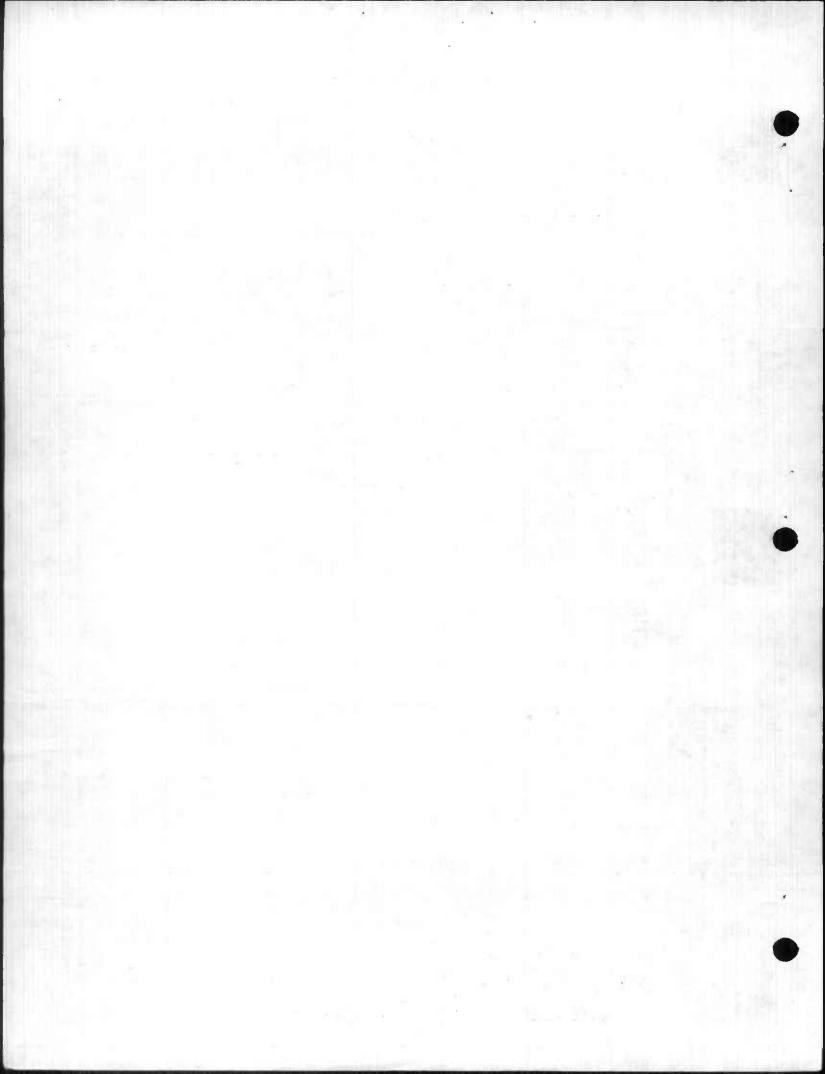
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ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** VIVIAN CARY MARCH 7,2000 5:40am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sax 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 10 M 20 F Months Days Hours Yrs. Director 213-56-0803 Oct. 27.1948 Washington DC the Maryland a notified at 10s State 10b. County 10c. City. Town or Location t 0d. Inside City Limits MYas 2 No Md. Prince Georges Landover Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ther must be c b 9212 Gary Lane 20785 U.S.A. Funeral 12. Was Decedenl Ever in U,S. Armed Forces(*) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 72 hours after 1♥ Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 "natural", or t Tyes 200No Specify: þ 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72. Department of Health and Montal Hygiene. Importants if item 27 is marked other than "retuing in jury or other traumatic event, the Market pages. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Helen Morton Luther Cary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Casselwood Drive, Upper Malboro, Md. 20772 Deeniece Curry Fontaine/Sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from Stele 4 Donation 5 Other (Specify) 3/13/00 Washington, D.C. GLenwood Cemtery 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Johnson & Jenkins Inc. arr 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Pertt. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Betw Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and the burlei-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed. Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? page 2 s 1 ☐ Yes 2 ☑ No t ☐ Yes 20 No certificate of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2€ No Certification: To Minpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 2 Accident 5 Pending investigation a effer de-el Director: Afr t ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide A 24 hours Funerel Direction ***Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely I (Check only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

MAR 10

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	Decedent's Neme (First, Middle Brian	Kennedy	Daly						2. Date of De Month FEBRU		5 2 000	3. Time of Death 11:30 P	
Examiner	4e Facility Name (If not institution MARYLAND SHOO		mber)	L.			b. City, Tow BALTIN		cation of Deet	4c. Count	y of Death		
Funeral Director	5. Sociel Security Number 217–56–3108	6. Sex 11 M 2 □ F	7. Age (In yrs. 50	last birthday) Yrs.	If Under 1 Months 1	Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, De Jan. 14	iv. Year) , 1950	9. Birthp Coun Mary		
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T is my	19e. Informent's Neme/Reletionship (Type, Print) Deborah Daly/ Sister 19b. Meiling Address (Street and Number or Rural Route Number, City or 500 Bay Dale Ct. Arnold, Maryland 21012								er, City or Town 21012	, State, Zip	Code)		
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	30 Name and address of person v	the completed caus	e of death (flor	n 23a) (Tyne	Print)								

DHMH 16 Ray 6/95

State Registrar

THEODORE MIKIN

FEB 2 9 2000

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Year MARY ANNA DIXON March 2000 7:45PM 4a Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Civista Medical Center Hours Min. 8. Dete of Birth (Month, Day, Year) Charles 7. Age (In yrs. last birthday) 95 Yrs If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) Days 1□M 2X F September 10,1904 Maryland 577-22-6959 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 USA 6335 Bumpy Oak Road Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: Never Merried 2 ■ Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Anna Kutilek Joseph Hruska 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6335 Bumpy Oak Rd. La Plata, MD 20646 Bernard Dixon/Son 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill 3/17/00 Suitland, MD. M00945 AREHART-ECHOLS FUNERAL HOME, P.A. of Funerei Service Licensee P.O. BOX 567 LA PLATA, MD. 20646 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feiture. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediete Ceuse (Finei MYOCARDIAL INFARCTION DAYS disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of) Pert II. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Yes 2 No

and physician s the burial Box 68760. Records, P.O. Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Physician/Medical

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Completed

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Certification:

edicai

Physician

/Medical

Examiner

Funeral

Director

Items 23e or 28e-f short lost must be notified at

'natural', or

is marked other

permit. Pages 1 and 2 should be fit.
Department of Health and Mental He
Important if Item 27 is market
any Injury or

Physician /Medical

Examiner

altimore, Maryland

Director

Funeral

Completed

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CONGESTIVE HEART CLOSTRIDIUM DIFFICILE ENTEROCOLITIS 25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 Pending investigation 1 Naturei 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piaca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyatcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

29b. Signatule and title of certifier

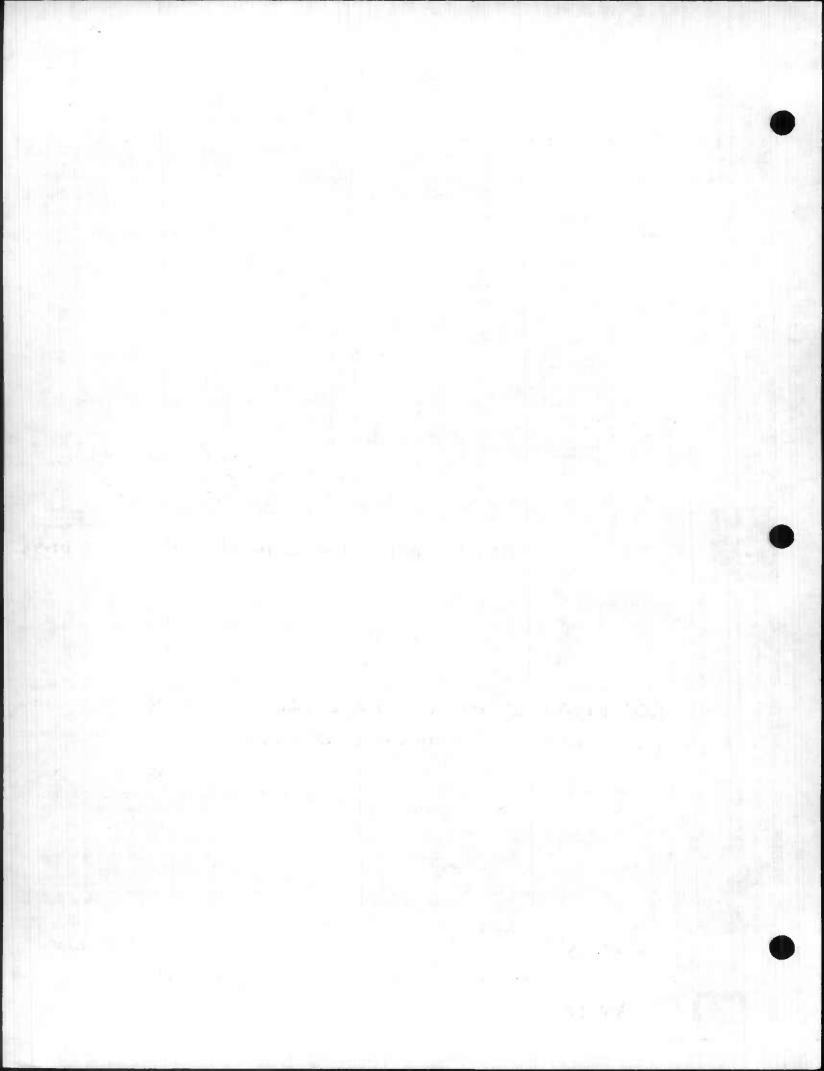
29d. Date signed (Month, Day, Year) 29c. License number MARCH 14,2000 D-28281

30. Neme and address of person who completed cause of deeth (ttem 23a) (Type, Print) Preston Nelson V. Benjers, MD

6B Industrial Park Drive SquareII, Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Dey, Year) MAR 1 5 2000 32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death March 14 2000 Sarah E. Davis 5:30AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 4110 Vineyard Place Marbury Charles If Under 24 Hrs. 8. Date of Birth Hours Min Month, Day, January 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days 30.1954 Washington, D.C 1 M 2 XPX Yrs. 46 212-66-4565 Usual Residence of Decedent 10e State 10b. Count 10c. City, Town or Location 10d. inside City Limits X Yes 2 No Maryland Charles Marbury 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? TISA 4110 Vineyard Place 20658 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Southern MD Hospital Billing Specialist 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Emogean Franklin Davis Roland 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 A Mattingly Ave. Indian Head, Maryland 20640 Brother Dale Davis-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3/17/2000 Clinton, Maryland Forest Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Funeral Home P.A. Aquasco, Maryland 20608 M00191 23a. Part1. Enter the unease, or complications that gaused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart in ure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final Amyotrophic Lateral Sclerosis disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 3 Probably 4 Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2000 1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home Statesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. injury at Work? 5 Pending 1 Yes 2 No Investigation 3 Suicide

Physician /Medical Examiner Examiner requires that the death certificate be axecuted

Department of important: If any injury or

Physician

/Medical

Examiner

Funeral

Director

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"natural", or items 23s or adical Examiner must be

Pages 1 and 2 should be filed within 72 hours after death nent of Health end Mantal Hygiena.

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Baltimore, Maryland 21215-0020

P.O. Box 68760.

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Funeral

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To the Hosp within 24 hor To the Fune completaly fi

25. Was case referred to medicel examiner? 27. Manner of Deeth 1-D Natural 2 A~

6 Could not be determined

28e. Place of Injury - Af home, farm, streef, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

4 Homicide

29a. Certifier

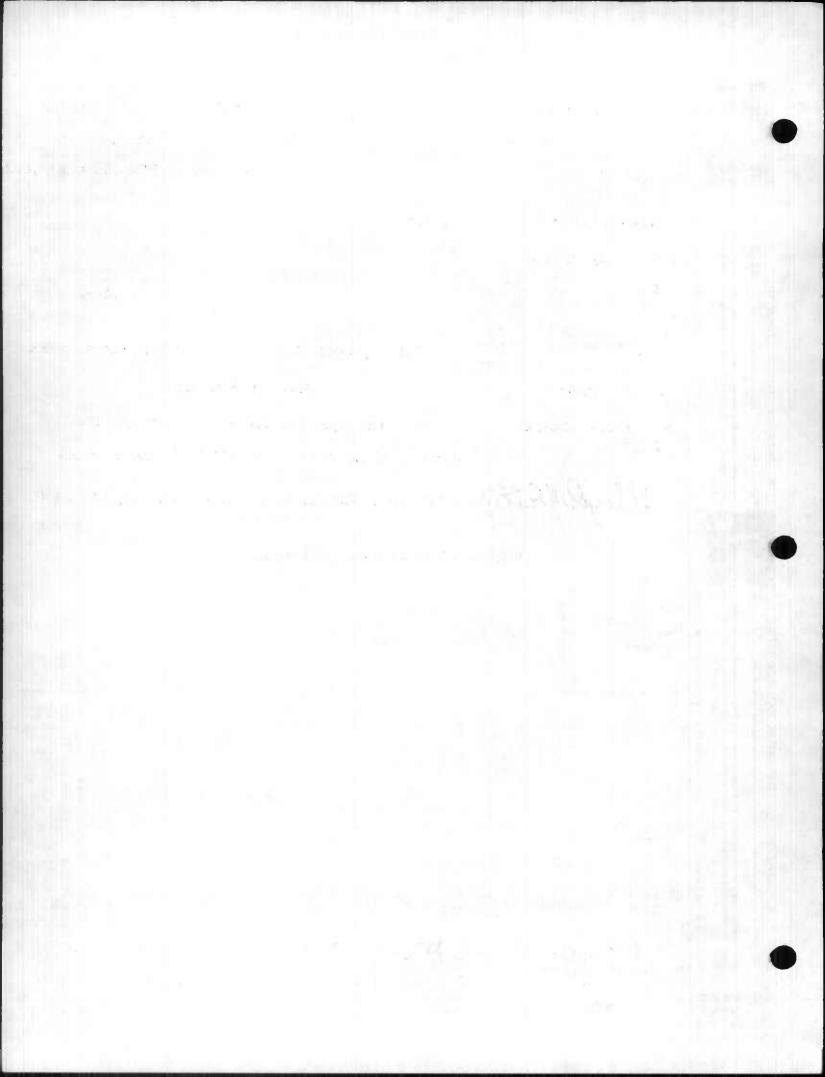
29c. License number D28352 29d. Dete signed (Month, Day, Year)

March 14, 2000

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend # 26. Per Phys. PGC 3-7-2000 cr Certificate of Death Rea. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day ZOOO **Physician** 10:45 PM DALE DORIS LUCINDA 03 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner District Herauts Prince yearges Milltown Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** 1 M 2 F Hours Deys Months Yrs. 229-42-705" IRGINIA Director Usual Residence of Deceden the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at District Heights 1 Ves 2 □ No MD Prince Georges Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Numbe with 6706 20747 Milltown DA Funeral death 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status filed within 72 hours after 1 Yes 20 If Yes, Give Year or Dates: 1 Never Merried 2 Married 20 No 1 Yes 2 No Specify: BLACK Baltimore, Maryland 21215-0020 Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hyglena. Elementery/Secondery (0-12) College (1-4or 5+) PRINATE NURSING UNIT CLERK marked other permit. Peges 1 end 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumerne) 17. Fether's Name (First, Middle, Last) Be HUNT QUEENTE EDWARD JOHNSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3700 KINSMAN WAY; HAMPTON, VA 23666 LINDA THOMAS / DAUGHTER 20b. Placa of Disposition (Neme of 20c. Location - City or Town, State 20e. Method of Disposition Date cemetery, cremetory or other piece, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ZEASANT GROVE CEMERNY 3-8-00 NEWPORTNEWS, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service Licensee 22. Name and Address of Fecility BIANCHI FUNERAL SORVICES 814 UPSHUR ST NW WASH, DC 20001 ant I. El ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical tmmediate Cause (Final ArdIAC diseese or condition resulting in deeth) **Examiner** Due to (or es a consequenca of): Examiner Ardo Meg M. buriel-tran Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es a consequenca of) pue that the death certificate be axed pertension physician s the buriel P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): USB BS for signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown ypercholesterolemin Records, Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en autopsy Chronic Hepatitis 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 1 Netural 2 Accident 5 Pending Investigation 1 Yes 2 No hours after death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Certifying Physicten: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier Medical (Check only one) within 2 4

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State Registrar 31. Dete filed (Month, Dey, Year) MAR 0 7 2000

29b. Signature and title of certifie

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30. Negre end address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

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29d. Dete signed (Month. Dev. Year)

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29c. License number

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29d. Date signed (Month, Day, Year) MARCH 14, 2000

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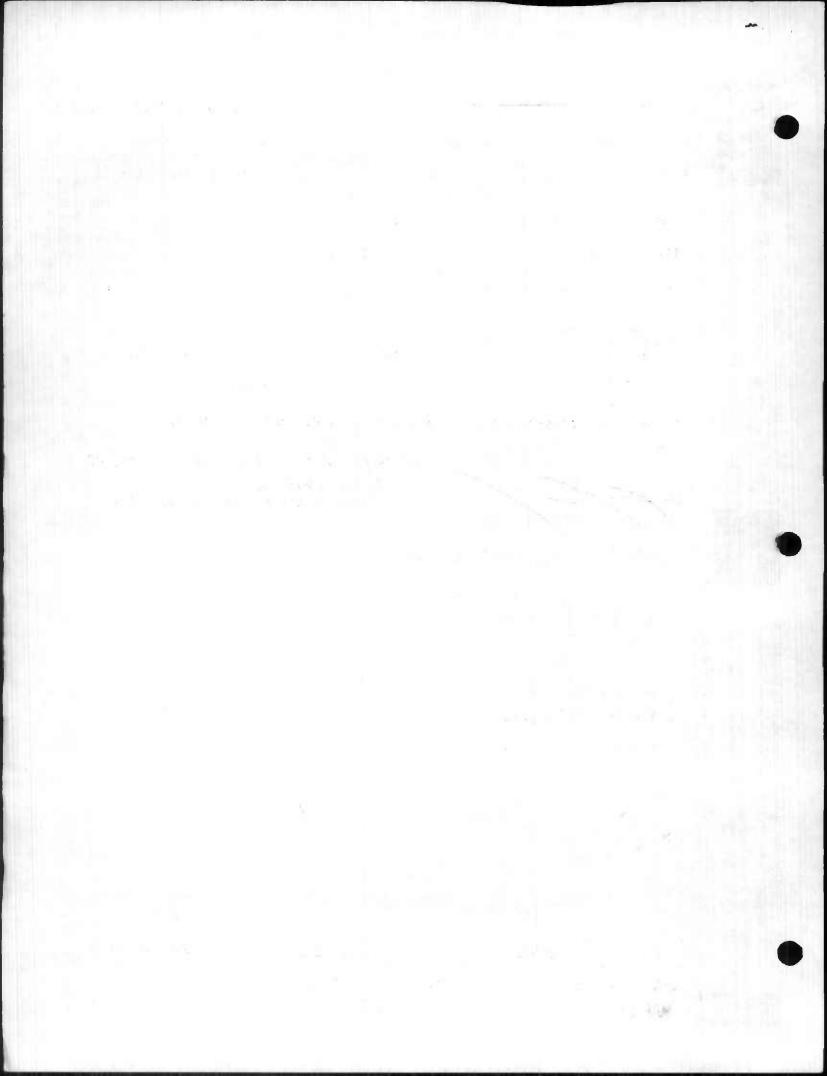
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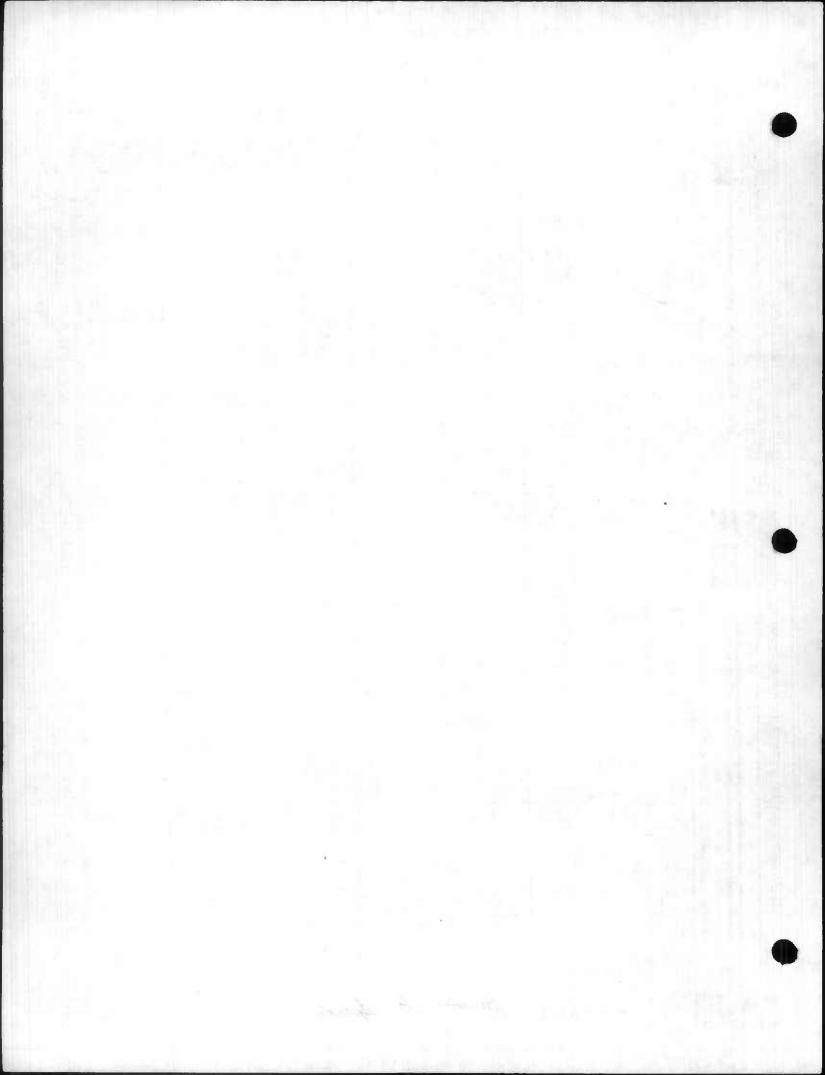
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaar Physician JEANETTE. NETTIE DENNIS Feb. 11,2000 6:55PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Center; Genesis ElderCare Salisbury, Md. Wicomico If Under 1 Year | If Under 24 Hrs. Months | Devs | Hours | Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months 216 - 38-763 1 M 2 L Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahos 1 Yes 2 No Director ma NICO MICO natural, or items 23s or 25s-f 10e. Street and Number 10g. Citizen of What Country? 21861 606 BSTOVEK USA Funera 14. Race - American Indian, 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0020 Specify: 1 Yes 2 No à 3 ₩idowed 4 Divorced Year or Dates: AMELICAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondery (0-12) Coitege (1-4or 5+) isAbil ball Sea der's Neme (First, Middle, Maiden Surneme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Them 27 is marked other any Injury or other treumstic event once. 17. Father's Name (First, Middle, Last) Be To LEL duc 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number/City or Town, State, Zip Code, OUER 606 WEST mac 21861 +KAR Salsbuly 20b. Place of Disposition (Neme of cemetery, cremetory or other) abs. Method of Disposition Dete 20c. Location - City or Town, State metory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State Solisburg MRM 4 ☐ Donation 5 ☐ Other (Specify) cc 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Mac 15 Abril 23a. Part1. Enter the diseese, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiretory errest Approximate Interval Between Onset and Death Physician /Medical tmmediate Cause (Finel diseesa or condition resulting in death) Examiner 0 burial-transit and Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be execu Box 68760 physiclan Physician/Medical the th Due to (or es a consequence of): 980 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. P.O. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Wes en eutopsy page 2 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 2 No Certification: To 1 Yes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Maturai death. 1 Yes 2 No 2 Accident 24 hours after deat Puneral Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 14 D-29349 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804 31. Date filed (Month, Dey, Year) FEB 15 2000 32. Pagistrer's Signature State Registrar



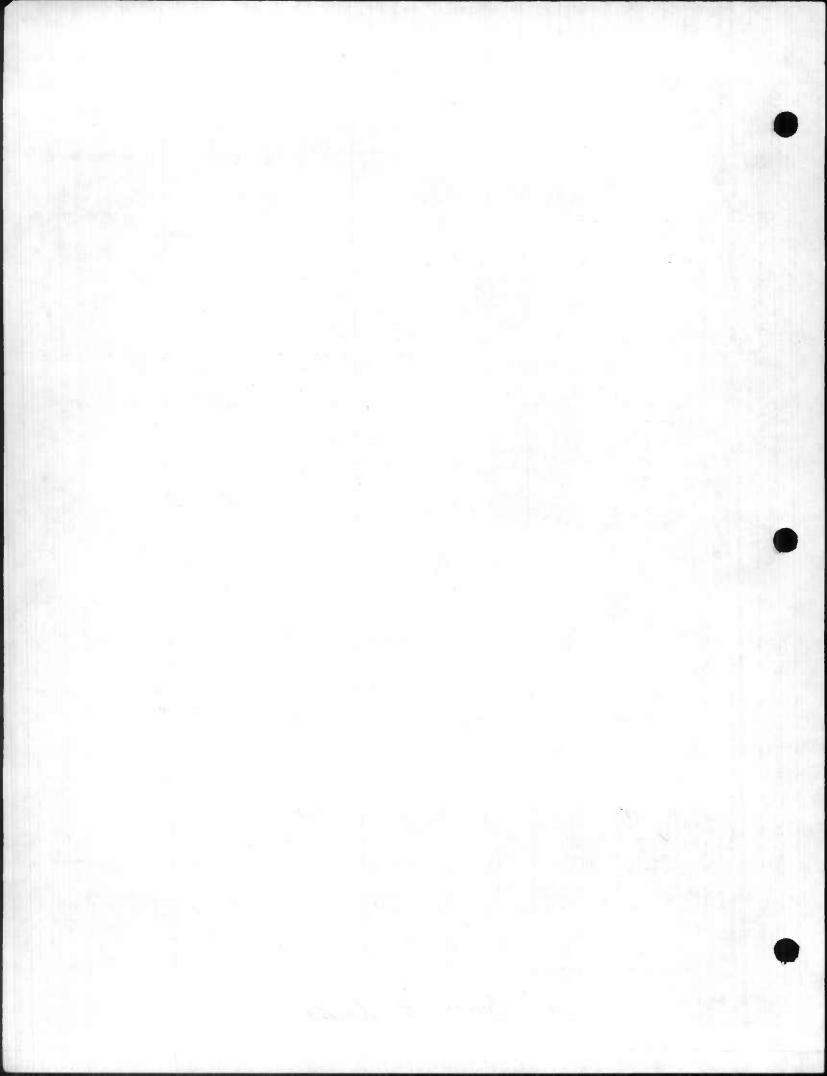
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neral		5. Social Security Number 6. St 220-12-1790		lest birthday) Yrs.	If Under 1 Year Months Days	Salis If Under 24 Hr Hours Mir	s. 8. Date of B	Wic	9. Birthplace (State or Foreign			
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his cartificate has been signed by the attending physician and a properties in important; if item 27 is marked other than "natural", or items 23a or 28a-f show a properties in director, page 2 should be datached for use as the burial-transit and injury or other traumatic event, the Modern Examined as the burial-transit and properties are interpreted by Physician/Medical Examiner. To Be Completed by Physician/Medical Examiner.	omo	Elementary/Secondery (0-12)	College (1-4or 5+)	Labo		0)		None				
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	Clarence Dashie					a Johns						
		19a. Informant'a Name/Relationship (7							Stete, Zip Code)			
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9		16. Pan1		St 82	ewart I	Tuneral	Home	,Md.218	0.4			
_		23a. Part1. Enter the disease, or comp shock, or heert failure. List only of			r the mode of dylr	ng, such as cardia	ac or respiretory	errest,	Approximete Intervat Between Onset and Death			
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	cation	27. Manner of Death 1 Neturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Year)	28b. Time of tnjury		y at k? Yes 2 □ No		how injury occur				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** FEB. 24, 2000 DOROTHY ROUNDS DAVIS 8:15 AM /Medical 4e Fscility Neme (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner WICOMICO SALISBURY, MD. SALISBURY CENTER; GENESIS ELDERCARE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** Deys 1□M 210 F Months Hours 94 214-10-9005 Director Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location t0d. Inside City Limits 25a-f show must be notified at 1 Yes 2 No Director Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? "natural", or hems 23a or 21801 514A Georgia Ave (Oak Hill Apts) U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Was Decedent Ever in U.S. Armed Forces? Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3℃ Widowed 4 Divorced Year or Detes: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. other than "n Elementery/Secondery (0-12) College (1-4or 5+) Secretary/Bookkeeper Ladies Department Store 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unpartment of Health and Mental Important: If them 27 is marked on my injury or other Pages 1 and 2 should be George Edwards Rounds Annie Hearn 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianna R. Holloway (niece) 1311 Woodland Rd., Salisbury, MD 21801 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Parsons Cemetery 2/26/00 Salisbury, MD 21, Signeture of Funeral Service Licenses 22. Neme and Address of Facility Holloway Funeral Home, P.A. 501 Snow Hill Rd., Salisbury, MD 21804 23a. Perf. Enter the disease, or complications that gaused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 0 Can co Examiner Due to (or as a consequence of): Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last physician and the burial-tran Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 4 signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ Completed 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of death? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital sapital or Attending Physician: hours after death. meral Director: After this certificativy filled in by the funeral director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1 Descripting Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 10 1104 HEALTHWAY DR., SALISBURY, WILLIAM ROBINS, M.D. MD 21804 31. Dete filed (Month, Day, Year) 32. Redistrar's Signeture State FEB 2 5 2000 Registrar

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month MARCH LILLIAN A. DIERKER 11, 2000 9:30am 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 11670 Carroll Clark Rd. Massey Kent If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Deys Hours Min. 1 M 2 KF Yrs. 220-07-7585 80 27 1919 Maryland April Usual Residence of Decedant 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 KNo Kent Massey 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 11670 Carroll Clark Rd. 21650 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 Yes 2 No 1 Nevar Married 20 Married 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Detes 15. Decedent's Education (Specify only highast grade completed) 18a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gustav Otto Koch Alice Kirby 19e. Intorment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Henry Dierker Sr (husband) 11670 Carroll Clark Rd. Massey, MD 21650 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 █ Buriel 2 ☐ Cremation 3 ☐ Ramoval trom Stata Massey Cemetery 3/14/00 Massey, MD. 4 ☐ Donatiop 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility M00510 Galena Funeral Home of Stephen Schaech Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Condiovajalar Disinie Due to (or as e consequenca of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): Due to (or as a consequenca ot): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 147721102 24b. Were eutopsy tindings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 Yes 2 No 1 Yes 2 No

Physician /Medical **Examiner**

Box 68760,

P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0020

and

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

MD

Funeral

Director

28a-f

the Medical Examiner must be notifi-

"natural", or flams 23a or

Hygiens.

permit. Pages 1 and 2 should be illed w Department of Health and Mental Hygien Important: if Nem 27 is marked other the any Injury or other tree

Examiner Physician/Medical by Completed Be Certification: To

attending physician for use as the burial the signed by t d be detach peen s page 2 certificate To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifici pletely

20

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 PAesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. tnjury at Work? 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, and dua to the cause(s) end manner as stated.

29b. Signeture and title of certifier 29c. License number 29d. Date aigned (Month, Day, Year) mas 16

30. Name and address of person who completed cause of deeth (frem 23a) (Type, Print)

Ludwig Eglséder MD 606 Dutchmans Lane Easton, MD. 21601 31. Date tiled (Month, Day, Year)

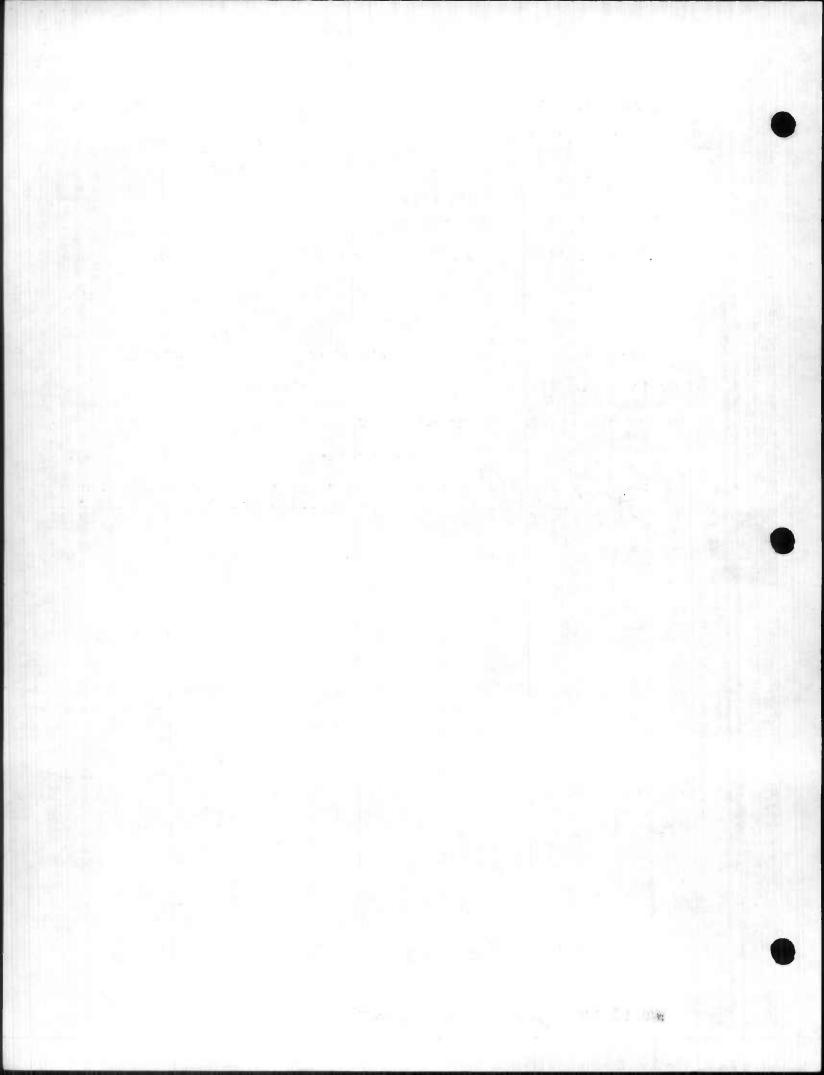
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated.

Registrar

Medical

MAR 13 2000

(Check only one)



State of Maryland / Department of Health and Mental Hygiene

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				Ce	rtificat	e of	Death			Reg. No.		2011
Physician /Medical	Decedent's Name (First, Middle, Last GLADYS MITCHE		LING						2. Date of D Month 03	D.	ბზი	3. Time of Death 9:12 PM
aminer	4a Facility Name (If not institution, give SOUTHERN MARYI		PITAL	CE	NTER		4b. City, To		ation of Dea			EORGE'S
al or	5. Social Security Number 6. Se 101–18–4187	x 7. Ag	e (In yrs. lasi 75	birthday) Yrs.	If Under Months		If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Year) June 2, 1924 Sou			place (State or Foreign intry) Ch' Carolina
tor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City											10d. Inside City Limits 1 XYes 2 No
al Director	10e. Street and Number 1821 Dewitt Avenue				10f. Zip		743			10g. Citizen of U.S.		ntry?
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If If Yes, Give Year or Dates:		 Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☑ No Specify: 						14. Ra Ble Specii	ck, White,	can Indian, etc. Black
Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondery (0-12)			(Give		rk done se retire	pation during most duthor		g	16b. Kind of E	Jernm	
To Be C	17. Father's Neme (First, Middle, Last) Roy Massey 18. Mother's Name (First, Middle, Maiden Sumame) Buelah Barnes											
	19a. Informant's Name/Relationship (7) Etta Webster/Cous									ber, City or Town Heights,		
	20a. Method of Disposition 1 Burial 2 Cremation 3 X 4 Donation 5 Other (Specify)		cem	etery, cre	matory or o	other pla	ce) Cemete	ry	Date 03/14 2000		own, State	
SOUGE.	21. Signeture of Fundal Service Licens	Br		J.	2. Name ar B. J	nd Addre	NS FU	y NERAL	HOME			
Examiner	Immediate Cause (Final disease or condition resulting in death)	0.	PULMO Due to (or as WITH Due to (or as	ABD(quence of):	AL :		ENSIC	ON		1	
Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	0	GASTRIC MASS Due to (or as a consequence of):									
y Physician	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of de 1 Yes 2 No 3 Probably 4 Unk											
Completed by			8	_		4	100		24a. Wa	s an autopsy formed?	a	Vere autopsy findings vallable prior to ompletion of cause of death?
ractor, page 2	25. Was case referred to medical examiner?						26. Place	of Death	(Check only	Yes 2 No	1	☐ Yes 2☐ No
10 To	1 ☐ Yes 2X No 27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	1 🔯 Inpatie 28a. Date of Inju (Month, Da		Outpatie		28c. Inju		2		sidence 8 Ot e how Injury occu		ify)
ed in by the funer Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury - At home c. (Specify)	, ferm, st	reet, factor	y, office		2	8f. Location City or To	(Street and Num own, State)	ber or Rui	ral Route Number,
Appletely fille	29a. Cartifler 1X Cartifying Phy	ner: On the basis of	examination	dge, deat and/or in	h occurred vestigation	at the t	ime, date en opinion, dea	d place, ei th occurre	nd due to the	e cause(s) and m e, date and place	nanner as , and due	stated. to the cause(s)
-	250 Signature and title of certifie		2				se number 16374			29d. Date sign	ed (Mopth	, Day, Year)
(5)	30. Name and linkess of person who co Anthony Thomas, M.	ompleted cause of d	South	Ba) (Type, ⊇rn A	Print) Avenue	s, S	uite :	#312, Washi	ngton	, D.C. 2	20032	

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day 2000

MAR DE 2000

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth 1. Decedant's Neme (First, Middla, Last) 2. Data of Death Day **Physician** March 3, 2000 GENEVA W. DOUGLAS 5:00 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Takoma Park Adventist Health Care MOntgomery If Under 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplaca (Steta or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 1□M 2□F 137-26-0250 114 Yrs. Director July 3, 1885 South Carolina Usual Rasidance of Decedent r 28a-f show 10b. County 10c. City, Town or Location 10d. Insida City Limits the Marylar 1 ▼ Yes 2 No Maryland Prince Georges Hvattsville Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic evant, the Modical Examiner must be a U.S.A. 20783 Funerai 1102 Chillum Manor Road death 12. Was Decedent Ever In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic evant, the Medical Examina 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 □ Nevar Marriad 2 □ Married 1 Yas 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Cotlege (1-4or 5+) Elemantery/Secondary (0-12) Self-Employed Domestic 18. Mothar's Name (First, Middle, Maidan Sumame) 17. Fathar's Nama (First, Middla, Last) Be Green Williamson Lulu (unknown) 19e. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) 1102 Chillum Manor Rd., Hyattsville, MD 20783 Mary Morton - Niece 20b. Place of Disposition (Nama of camatery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Date 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata New Zion Bapt. Church Cem 3-11-00 Rock Hill, S.C. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22 Nama and Address of Eacility
Marshall's Funeral Home, Inc. 23a. Partz Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, but k, or heart failure. List only one cause on each line. 4217 9th Street N.W. Washington DC 20011 Approximate tnterval Batween Onset and Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in daath) 1 week a Complete Heart block Examiner Dua to (or as a consequence of): Examiner 1 week b. Myocardial Infarction attending physician and for use as the bunal-transit certificate be executed Saquentially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Last Dua to (or as a consaquance of): vears Atherosclerosis Physician/Medical Due to (or as a consequence of): vears d. Hypertension signed by the a Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4∑ Unknown Stroke, Pneumonia þ 24b. Wara autopsy findings available prior to Completed 24e. Wes an eutopsy completion of cause of deeth? page 2 s has 1 ☐ Yes 2 ☐ No certificate 1 Yas 2 No Physician: director, 25. Was casa refarrad to medical axaminar? Be 26. Pleca of Death (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 43 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 2 this 28a. Data of Injury (Month, Day Year) funeral 28d. Describe how trijury occurred 27. Mannar of Death 28h Time of 28c. Injury at Work? Certification: After 1 XNatural 5 Panding 1 Yas 2 No death. investigation 2 Accidant s after death the 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 ☐ Homicide 24 hours Hospital 29a. Cartifian 1🖄 Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely fi edicai (Check only one) 2 Medical Examiner: On the besis of examination and/or invastigetion, in my opinion, deeth occurred et the time, date and piece, and dua to the causa(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signature and titla of contifiar 29c. Licensa number Naini MD Rushid D 39372 March 7, 2000 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) Rashid Baghai, M.D. 344 University Blvd. West, Suite 324 31. Data filad (Month, Day, Year) 32 Registran's Signatura MAR 08 2000 Registrar

DHMH 16 Rev 6/95

3altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene

			Certi	ricate	OT L	Jeam		F	Reg. No.			
1. Decedent's Name (First, Middle, Las						Date of Dec	Day	Year	3. Time of Death			
Joseph L.	Dillar	d						March	- '		11:07 an	
4a Facility Name (If not institution, give	street and number)				4	b. City, Town,	or Local	ion of Death	4c. Count	y of Death		
Washington Adver	ntist Hospi	tal				akoma				gomer	у	
Social Security Number 6. Security Number	ex 7. Age (In yrs. last bir	A	f Under 1 fonths	Yeer Deys	If Under 24 I Hours N	Ain.	Date of Birt (Month, Day	Year)	9. Birthp	lece (Stete or Fore	
218-38-9325	MW 201	56	Yrs.				Jı	me 24	1943	Ten	nessee	
Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Loon	ion						1	Od. Inside City Lim	
											1 ☑ Yes 2 ☐ f	
Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Chizen of Whet C												
10e. Street and Number				10f. Zip C		700			-		itry?	
5612 37th Avenue			20782						U.S.A	100		
11. Merital Status	12. Wes Decedent Ev Armed Forces?	er in U,S.	13. Wa	s Deceder es, specify	nt of Hi / Cuba	ispanic Origina n, Mexican, Pr	(Specif	y Yes or No- an, etc.)	14. Ra Bia	ce - Americ ick, White,		
1 Never Married 2 Merried	1 ☐ Yes 2 ☒ No If Yes, Give		10	Yes 2	ON D	Specify:			Speci	y: Whi	to	
3 Widowed 4 Divorced	Year or Dates:								101 101 1 15			
15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a.	(Give kin	d of work	done c	furing most of	working	6.77	16b. Kind of E	Susiness/inc	dustry	
Elementery/Secondary (0-12)	College (1-4or 5+)		Groundskeeper						Aliaria	s Realty, Inc.		
8 17. Father's Name (First, Middle, Last)			GIOU	Huski	Т		Nama /F		Maiden Suma		icy, inc.	
										1110)		
Rufus Dillard	San a Park th	1 2 2 2	240.00	A shake in the	04-			Loveg		Chr. to T	Codel	
19a. Informant's Name/Relationship (7	n, State, Zip	20782										
Barbara Ann Dilla	rd - Wile	20b. Piece of				nue, ny	-	Dete	, Mary			
20e. Method of Disposition 1 Burlar 2 Commation 3 D	Removal from State	cemeter	y, cremat	ory or oth	er plec	e)	1					
4 Donation 5 Other (Specify	Metro	-	olitan Crematory 3/12/20					OOO Alexandria, Virginia				
21. Signature of Funeral Service Licenses 22. Name end Address of Facility Gasch's Funeral Home, P.A.												
1/ Made	Mu	1	47	39 Ba	1ti	more A	venu	e, Hya	attsvil	le, M	D 20781	
23a. Part T. Enter the disease, or companions, or heart failure. List only of	olications that caused the	e death. Do								1	Approximate Interval Between	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. DIABETES	e to (or es e	conseque Ltus	nce of):			9				10 Years	
Part II. Other significant conditions co	d	not resulting in	the unde	ortying cau	ise give	en in Part I.			obacco ues c		o the cause of dea	
							- 64					
				24a. W pe					en autopsy rmed?	av	ere autopay finding allable prior to mpletion of cause death?	
								101	res 2 No	1[Yes 2□No	
25. Was case referred to medical exeminer?						26. Plece of	Deeth (Check only o	ne)			
1 Yes 2 No	Hospitel: 1 Inpatient			3□ DOA	Oth	4 LI NUISI	-		denca 6 □O		(y)	
	28a. Date of Injury (Month, Day)	'ear) 28b. 1	Time of njury		. Injun	k?	28	d. Describe I	now Injury occu	ırred		
27. Menner of Death	(MOHIII, Day I			M 1 Yes 2 No								
27. Menner of Death 1 ANaturel 5 Pending 2 Accident investigation						28e. Placa of Injury - At home, farm, atreet, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route for City or Town, State)						
27. Menner of Death 1 Anaturel 5 Pending	28e. Place of Injury		rm, atreet	, factory,	offica		281	Location (S City or Tox	Street end Num m, State)	IDE OF FIGE	71001011011001,	
27. Menner of Death 1 X Naturel 2 Accident 3 Suicide 4 Homlcide 29a. Cartifier 1 Certifying Phy	28e. Place of Injury	Specify) ny knowledge aminetion en	, deeth or	ocurred at	the tim		laca, and	City or Tov	m, State)	nanner es s	tated.	
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DHMH 16 Rev 6/95

No. 15 -

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State of Maryland / Department of Health and Mental Hygiene

MaryLand Prince Goerge's Dxon HiLL 10e. Street and Number Gotton HiLL Road #203 10e. Street and Number Gotton HiLL Road #203 10e. Street and Number Gotton HiLL Road #203 11. Martial Status 12. None Problem Status 12. None Problem Status 13. Martial Status 14. Race - American Indiann, Block, Winks, etc. 15. Special Comments Indiann, Block, Winks, etc. 16. Special Race of work does and martial Race of				Certific	cate of Death	R	eg. No.	0 03	1020				
HOLY CROSS HOSP Trail From 1970 Stricker Spring From 1970 From	/Medical	MARY E	DEAHL	na .	th City Town	Month 3 -	6-26	200 14	ma of Death				
Use of Residence of December Use of Residence of December Use of December Us	Wedgical Examiner manufacture in the factor of them 23s or 28s-f show other traumatic event, the factor of the fac		va street and number)				100						
To State Internal Foundation of the State and Hamster Copy of the		577-44-5394	101 AYE	Mor		s. Data of Birth in. (Month, Day, October	27, 1933	9. Birthplace (S Country) Washingtor	nata or Foreig				
In Notice Married 20th Married 10 10 10 10 10 10 10 1	and ahow filed at	10a. Stata 10b. County		, .			10d. Inside City Limit						
10 New York Specify	23a or 28 at be not	10e. Street and Number 6265 Oxon HiLL Roa	d #203	10	20745	1	og. Citizen of V Unit	What Country? ced States	1				
19. Melting Address (Sineer and Number or Rural Roads Number City or Town, State, Zp Code) 19. Informeric's Name Practicularity (Russ) 19. Melting Address (Sineer and Number or Rural Roads Number City or Town, State, Zp Code) 19. Informeric's Name-Practicularity (Russ) 19. Melting Address (Sineer and Number or Rural Roads Number City or Town, State, Zp Code) 19. Informeric's Name-Practicularity (Russ) 19. Melting Address (Sineer and Number or Rural Roads Number City or Town, State, Zp Code) 19. Informeric's Name-Practicularity (Russ) 19. Melting Address (Sineer and Number or Rural Roads Number City or Town, State, Zp Code) 19. Informeric's Name-Practicularity (Russ) 19. Melting Address (Sineer and Number or Rural Roads Number City or Town, State, Zp Code) 19. Informeric's Name-Practicularity (Russ) 19. Melting Address (Sineer and Number or Rural Roads Number City or Town, State, Zp Code) 19. Informeric's Name-Practicularity (Russ) 19. Melting Address (Sineer and Number or Rural Roads Number City or Town, State, Zp Code) 21. Sporture of Funeral Sarvice Licensee 22. Name and Sporture City or Town, State, Zp Code) 23. Part I. Enter the dissease disdiffinifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 19. Mean and sporture Sporture City or Name Address (Russ) 19. Mean and sporture City or Name-Practicularity (Russ) 19. Mean and sporture Ci	by Ja	1 Never Married 20X Married	Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva										
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4 Concention 5 Cheer (Specify) 21. Signature of Funeral Service Licensee 22. Name and address Facility Home, Inc. 4339 HINT PLICE, N.E. WaSHINGTON, D.C. 23a. Part1. Enter the dispart List only one ceuse on each line. Approximate phose and address Facility Home, Inc. 23a. Part1. Enter the dispart List only one ceuse on each line. Approximate phose and below one of the facility List only one ceuse on each line. 25a. Part1. Enter the dispart List only one ceuse on each line. Approximate phose and below one and list one of the facility Color	T le m traum												
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30 Name and address of tearing who introduced cause of death (from 23a) (Type Print)	direct direct	examiner?	Hospital: 1 hopatient 2	ER/Outpatient 3[Other			ar (Specify)					
30 Name and servers of transport of cause of death (from 23a) (Type Print)	tor: After the the funeral cation:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	1 Yas 2 No				Mumbar				
30 Name and servers of person who convoled cause of death (from 23a) (Type Print)	rfilled in by	4 Hornicios	building, etc. (Speci	ify)		City or Town	n, Stete)	8 19	Trumber,				
30 Name and advisors of the trust who controlled cause of death (from 23a) (Type Print)	pletely edic	(Check only 2 Medical Exa	miner: On the basis of examin	ation end/or investig	ation, in my opinion, death oc	curred at the time, d	ata and place,	and due to tha ca	use(s)				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yung Son PANG. 1500 Forest Gler) Selver Spring MD	Ton	29b. Signature and titla of certifier	by mo		29c. License number D 552 (3	9d. Data signer	d (Month, Dey, You	sar)				
	25)	30. Name and address of person who	PAN6 - 157		- Gler S:	luer sp	ine	MD					

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 2, Day 2000 Physician Lillian Arabelle 8:00 pm DeGourse /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Months Hours 577-09-4623 July 28, 1917 Director Maryland Usual Residence of Decedent 10n. State 10b. County 10c. City. Town or Location Items 23s or 25s-f show 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince George's Berwyn Heights 10s Street and Number 10f. Zip Code 10g, Citizen of What Country? 8718 62nd Avenue U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien. Black, White, etc 72 hours efter 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White p 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within 72 Department of Health and Mentel Hyglene. Important: if item 27 is marked other than 'nath any injury or other treumatic avant, the Medias and 6. Elementary/Secondary (0-12) College (1-4or 5+) Accounting Department University of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Mayo Attick, Sr. Lillian Bursey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Degutis - Niece 10015 West Mill Pond Drive, Bishopville, MD 21813 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 3/6/2000 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Physician SEPTICEMIA /Medical Immediate Cause (Final Therteen disease or condition resulting in death) Examiner Days A SPIRATION PNEUMONIA Examiner ettending physician and for use as the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as HEMIPLEGI A 68760 Physician/Medical that initiated events resulting in death) Last Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.0. DISEASE 1 Yes 2 No 3 Probably 4 Unknown Records, by ARDIAC AVERYIHMIA 24b. Were autopsy findings aveilable prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No of Vital Attanding Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitat: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No this r daeth. 27. Manner of Death 1 Natural 28a, Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: Division 5 Pending investigation 1 Yes 2 No Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide after 8 To the Hospital o within 24 hours af To the Funeral Di completaty filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number MARCH 2nd 2000 222910 physician) 4700 BERWYN HOUSE ROAD, COLLEGE PARK MD 20704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar'a Signature 31. Date filed (Month, Day, Year)

Registrar **DHMH 16 Rev 6/95**

State

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3/3/00 AMEND# 4a.4b. 26 per phy AACO Health cmcertificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** CAROL EVANS 0818 FRAN CES 2000 /Medical 4a Facility Neme (If not institution, give street end number)
The Annapolitan. 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Ritchie Hwy Anne Arundel The Annapol Arnold Nundar 24 Hrs If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours Min 1□M 25€F Yrs. 56 June 1,, 1943 Maryland 217-40-5188 Director Usuel Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Mod cal Examiner invest on notified at the Merylar Anne Arundel Arnold 1 ☐ Yes 2 No Director 10g. Citizen of What Country? USA 10f. Zip Code 10e. Street end Number 21012 1151 Baltimore & Annapolis Blvd. Funeral 14. Raca - American Indien 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritei Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 White 1 ☐ Yes 2X No Specify: Specify: p 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 7 Health and Mental Hygiene. Montgomery County Collaga (1-4or 5+) Elamentary/Secondary (0-12) of MD Government Elections Administrator 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Mary Bernice Pfaff Frank C. Serio 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) A Pages 1 a spartment of Health Important If New 27 'sy Injury or of 1151 Baltimore & Annapolis Blvd., Arnold, MD 21012 Christine Marks/ daughter 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State Feb 28 1 ☐ Burial 2 SCremation 3 ☐ Removal from State Baltimore, MD 4 Donation 5 Tothey (Spec Metro Crematory 2000 Barranco & Sons, 21 Signature of Funeral Service Moory P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 not entar the mode of dying, such as cardiac or raspiratory arrest, Approximata Interval Between Onset and Death Physician Immediate Cause (Final disease or condition CEREBROUNSCULIR ACCIDENT /Medical 4- MUNTHS HYPERSENSITIUTY VASCULITES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated evants resulting in deeth) Lest Exa POLMONIEY CHIBMIC OBSTRUCTIVE physician the burta P.O. Box 68760 Physician/Medical Due to (or es a consequanca of) = 950 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown USE signed I Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of daath? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case rafarred to medical examiner? 28. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Presidence 8 Nother Specify S Hospital: 1 Yas 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA this Family Home 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? 28a. Data of Injury (Month, Dey Year) After ! 1 Matural 5 Pending efter death. 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 29e. Certifier 1 Certifying Phyalcian: To the best of my knowledga, deeth occurred at the tima, deta end pleca, end due to the cause(s) and manner es atated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date end piece, and due to the cause(s) and menner stated. (Check only one) To the vithin 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35621 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 4191 MT R DISMORNA, MO MO DAVID

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

MAR 0 3 2000

32 Registrer's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death / Month **Physician** 4:00 pm ANTHONY WILLIAM ELLIS Fehruan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (Il not institution, give street and number) Examiner DOCTORS HOSPITAL LANHAM PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 7 Ann (In vrs. last hirthday) **Funeral** Days 10XM 2DF Months Hours 579-94-4274 Director 29 NOVEMBER 26, 1970 WASHINGTONDO Usual Rasidence of Decedent 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits No Yas 2 No Director PRINCE GEORGES DISTRICT HEIGHTS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 6108 ATWOOD ST. 20747 UNITED STATES Funeral Rema : 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status then "natural", or item the Medical Examiner. Never Married 2 Married 1 ☐ Yas 2 ☐XNo If Yes, Give Year or Dates: 1 Yes 2 No Specify Specify: BLACK by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiene. Elamentary/Secondery (0-12) College (1-4or 5+) ROOFER PRIVATE 17 Father's Nama (First Middle Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be 1 and 2 should be Health and Mental JOHN ELLIS LOLA RANDALL 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If itam 27 any injury or other tr 5601 KEPPLER RD, TEMPLE HILLS MD 20748 JOHN ELLIS / FATHER 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 6 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) HARMONY MEMORIAL PARK 3-2-00 LANDOVER, MD 22. Nama and Address of Facility S. POPE FUNERAL HOME 21. Signature of Funaral Service Licenses 11166 M1085 5538 MARLBORO PIKE, FORESTVILLE, MD Enter tha disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, or haart feilure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examine Examiner sician and burial-transit Sequantially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lest physician the burial Box 68760, Physician/Medical Due to (or as Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 6 1 Yes 2 No 3 Probably 4 Unknown signed I Records. P 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 2 No 1 Yas 2 No of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending 5 Pending invastigation 1 Yas 2 No 24 hours after death. 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 8 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 02

Registrar

MAR 0 6 2000 **DHMH 16 Rev 6/95**

31. Data filed (Month, Day, Year)

Moustafa Shamm, M.D. 2. Régistrar à Signature

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

575 Main Street S-253 Laurel, Md.

20706

Since Since

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Month 1. Decedent's Neme (First, Middle, Last) Year Physician 3, 0815 2000 John Edwards March /Medical 4b. City. Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Hyattsville Prince Georges 3703 Nicholson Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) July 23, 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Deys Months 579-05-8403 1₩ M 2□ F 82 Yrs. Maryland Director Usuel Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 20 No Director Maryland Prince Georges Hyattsville 10g. Citizen of What Country? 10e. Streat and Number 10f. Zip Code 3703 Nicholson Street United States 20782 Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus filed within 72 hours after 1 ☑Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1942 to 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) C&P Telephone Technician 18. Mother's Neme (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy Important: if item 27 is marked other any injury or other treumatic event page. 17. Fether's Neme (First, Middle, Last) Be George A. Edwards Margaret Sturgis 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3703 Nicholson Street, Hyattsville Maryland 20722 Donna Edwards 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Cedar Hill Cemetery 4 ☐ Donatton 5 ☐ Other (Specify) 3-6-00 Suitland Maryland 21. Signature of Funerel Service 22. Name and Address of Fecility Fort Lincoln Funeral Home WWW.00907 ausu Brentwood, Maryland 20722 23a Pert1. Enter the disease or complications that aroused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or hear feilure. List only one cause or each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel Congestive Heart Failure disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Mitral Valvular Disease that the death certificate be executed physician and s the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence ot): Atrial Fibrillation Box 68760 Physician/Medical Due to (or es a consequence of) 950 Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? P.0. the signed by d 3⊡Probably 4 Unknown 1 ☐ Yes 2 ☐ No Hypothyroid Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? peed Cerebrovascular Accident pege 2 has 20 No 1 Yes 1 ☐ Yes 2 ☑ No certificate or Attending Physician: director, Be 25. Was case reterred to medical axaminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation n 24 hours after death he Funeral Director: A pletely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 29e. Certifier edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end manner stated. (Check only one) within 2 To the the th 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartif 29c. License number D 20009 address of person who completed cause of death (Item 23a) (Type, Frield)
Lockwood Drive, Silver Spring Maryland 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State MAR 0 6 2000 Registrar

DHMH 16 Rav 6/95

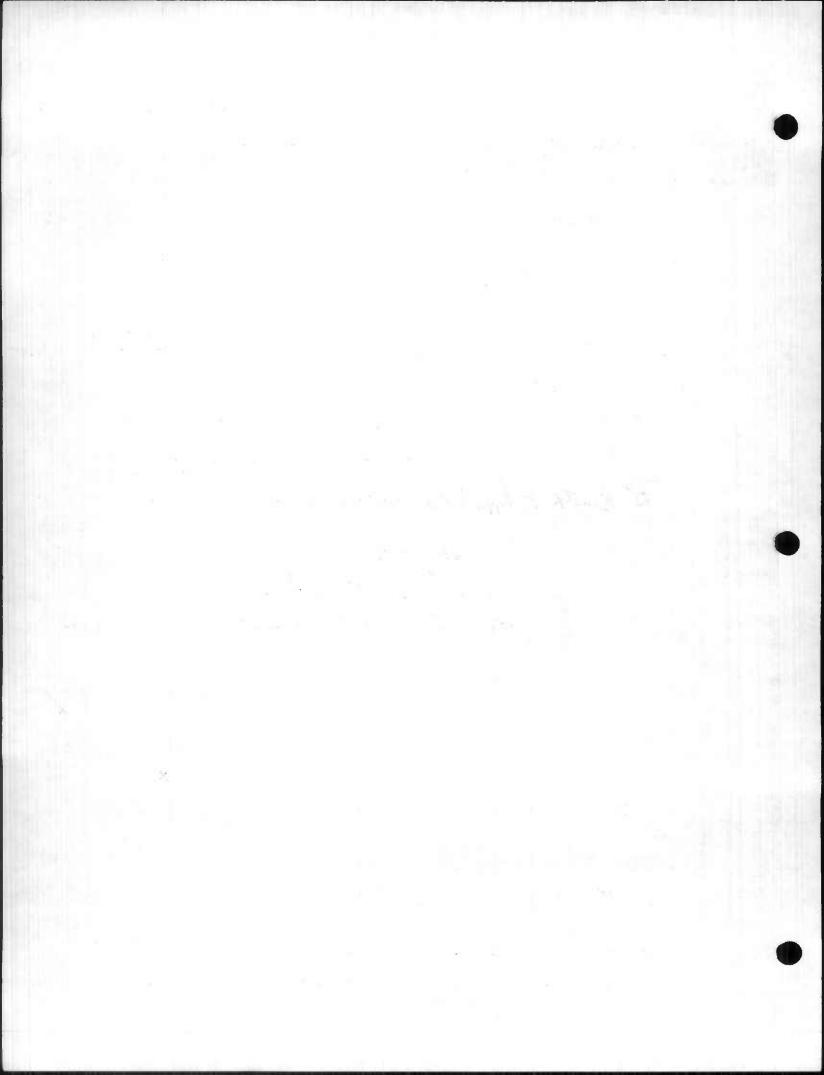
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AMEND# 10				mh	Cer	tificate of	Death			Reg. No.				
Physician /Medical	Decedent's Nan	Roberta 1	Franklin						Month March	3, 20	Yeer	3. Time of Death 10:50 AM		
Examiner		ne Arundel	Medical Ce	enter			4b. City, Tow Annapol	is		Anne	of Death Arunk	iel		
Funeral Director	5. Social Security I 577-54-1 Usual Rasidence of	731	Sex 1□M 2∏F	7. Age (In yrs. last i	Yrs.	Months Days	Hours	Min.	Month, Da une 5,	y, Year)	Cour	place (Stata or Foreign http: yland		
or 28a-f show be notified at Director	10a. Stata Maryland	10b. County Anne A	rundel	10c. City, To		ation 10f. Zip Code				100 Chinas of		0d. Inside City Limits 1 ☐ Yes 2 No		
South v	10e. Street and Nu 58 11. Marital Status	Swan Ci	rcle Rd.	dent Ever in U.S.	13. V	2075 Vas Decedent of I Yes, specify Cub		n? (Specif		10g. Citizen of US	SA ce - Amaric	can Indian,		
or ath	1 ☐ Never Man 3 ☐ Widowed		If Yes, Give	2 ()(No		Yes, specify Cub		Puerto Rio	can, etc.)	Specil	Wh	ite		
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- ESN'S	20a. Mathod of Dis	ene Winzent	warth/ Sist	20b. Place	5868 of Dispos	Address (Street SWamp Swan Circ sition (Name of	le Rd.	Deale,						
mit. Pages 1. partment of Hs portant: if then ty injury or other										Galesvil lor Fune				
Physician	23a. Part1. Enter shock, or hea	tha disease, or court faiture. List only	mplications that ca	used the death. Do	o not ente	147 Duke of the mode of the	ng, such as c	ardiac or r	espiretory ar	-	is, Md	Approximate Interval Batween Onset and Death		
/Medical Examiner	Immediate Causa disease or condition rasulting in death)	(Final on	o	Respin Due to for as	a consequence	uence other	ail	Pul	mone	Die Die	fa < 4	1 hour		
at the death certificate be associed by the attending physician and eteched for use as the burial-transit Physician/Medical Examiner	Sequentially list or if any, leading to ir cause. Enter Und. Cause (Disease or that initiated event resulting in death)		c	Due to (or as a	a consequ	Jence or):					-1 30	. 10 1		
	Part It. Other signi	ficant conditions	contributing to dea	ath but not resulting	in the un	derlying cause gi	ven in Part I.		23b. Dld 1	,		the cause of death		
The law requires that the rate has been signed by the page 2 should be detach	Atr	nal K	brillati	YOU					24a. Was perfo	an autopsy med?	av	are autopsy findings allable prior to mpletion of cause death?		
vian: The artificate h ctor, page	25. Was case refai	-11-37	Hospital:			¥ Ott		of Death (0	1 🗆 Y		10	Yas 2□ No		
eath. or: After the fune	1 Yas 2) 27. Manner of Deal 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Data of (Month)	Injury 28b of Injury - At home, g, etc. (Specify)	Time of Injury	M 28c. Inju	4LI Nurs	280	d. Describe i		rred	iy) al Routa Number,		
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff.	29a. Certifier (Check only one)	Certifying P	hysician: To the b	pest of my knowled	ge, death	occurred at the ti estigation, in my o	ma, date and opinion, death	place, and	due to the	cause(s) and m	anner as s	tated. o tha cause(s)		
To the within To the comple	29b. Signature and	byne	D Ba	b~	ے	29c. Licens	3856	3		29d. Data signa	431	0		
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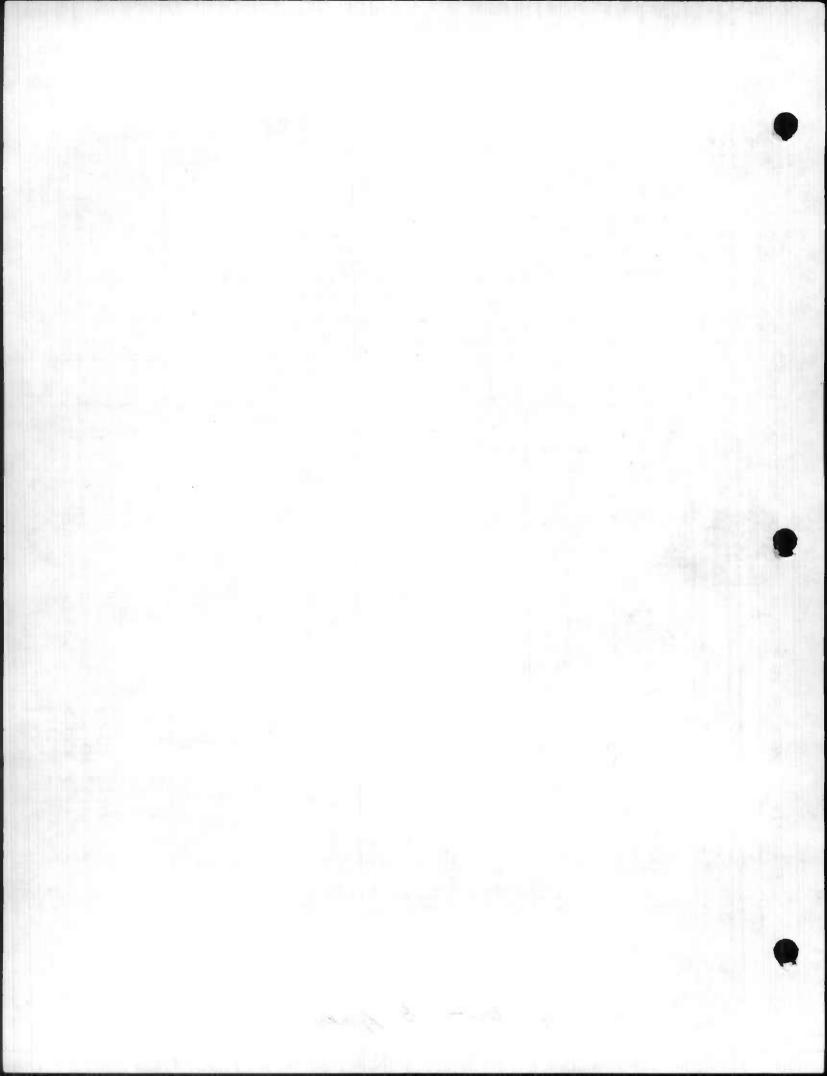
State of Maryland / Department of Health and Mental Hygiene 10 0000

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п	Physic	ian	1. Decedant's Nama (First, Middle, Last) 2. Dete of Death Month Dey Year											
	/Medi		WILLIAM W FARI	LOW, SR					MARCH	5, 2000		11:40 PM		
	Exami		4a. Fecility Neme (If not institution, gi	va street and numb	ar)			4b. City, Town, or	Location of Death	4c. County	of Death			
			101 ROSEBERRY AV	/E				SALISB	URY	WIC	only of Death COMICO 9. Birthpiaca (State or Country) MARYLAND 10d. Inside City 1 Yes of What Country? A. Race - American Indian, Black, Whita, atc. Pacify: WHITE of Businass/Industry DLEUM PUMP NUFACTURER PROMICE PARTICIPATION AR, DELAWARE MAIN ST. SBURY, MD 218 Approximate Intiarval Betwonsel and D MINION Contribute to the cause of the Country of)		
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	ith the Marylar or 28a-f show	5					Ι,	1 Yas 2 No						
		Director	MARYLAND WICOMICO SALISBURY							**				
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Maryland			19a. tnformant's Neme/Ralationship	(Type, Print)		19b. Mailin	ng Addrass (St	reet and Number or R	u <i>ral Routa N</i> um <i>be</i>	or, City or Town,	State, Zip	Coda)		
	1 end 2 Health e em 27 is		NELLIE W. FARLOW	- WIFE		101 F	ROSEBER	RY AVE	SALISBUR	Y. MD 2	1804			
ē,	it of Heal		20a. Mathod of Disposition		20b. PI	ace of Dispo	sition (Nama o	of	Data			wn, Stata		
Baitimore,	permit. Pages 1 Depertment of H Important: If Ite eny Injury or ot		1 N Burial 2 □ Cramation 3 [4 □ Donation 5 □ Other (Speci	fy)	nta l		natory or other		3/11/00					
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00/00	cete be executed physician end s the bunal-transit	Medical	that initiated avents resulting in death) Last	C.	Dua to (or	as a conseq	uance of):					0		
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	es that the de igned by the a be deteched									23b. Did tobecco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknow				
ה'א מי	uires t	d by							24e. Was	an autopsy	24b. Wa	ara eutopsy findings		
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DIVISION	Attending Process. Certification:	Natural 5 Pending invastigation		Day Year)	injury		Work? 1 ☐ Yas 2 ☐ No							
0	or Attendi after death. Director: A I in by the fo	fica	3 ☐ Suicida 6 ☐ Could not b		iniury - At ho	ma farm str	eat, factory, off	lice	28f. Location (5	Street and Numi	er or Rura	I Route Number.		
3	는 는 마이	erti	4 Homicida	building,	atc. (Specify)	,,,		City or Tou			,		
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	within To th	X	29b. Signetura and title of certifiar					cansa number		29d. Date signe	d (Month,	Dey, Year)		
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State of Maryland / Department of Health and Mental Hygiene 00 09627.

				Cei	rtificate	of L	Death			Reg. No.		001	
	1. Decedent'a Name (First, Middle,	Last)							2. Date of De Month		Year	3. Time of Death	
Physician /Medical	GEORGIA	WHELI	PLEY	F	FOURCAL	E			Februa	ary 19,2	ry 19,2000 2		
Examiner	4e Facility Neme (If not institution, Atria Assisted	-	im <i>ber)</i>			4		isbu	ocation of Deat	4c. County of Deeth Wicomi			
Funeral Director	5. Social Security Number 079–38–1764	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. las 93	st birthday) Yrs.	If Under 1 \ Months D	ear eys	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Di January	25,1907	9. Birthy Cour Nev	place (State or Foreign http) York	
2 .	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location									- 12			
with the Maryles a or 28a-f show be notified at Director	Maryland Wico	mico		Salish	oury							0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
23a or 2 unit be no	100. Street and Number 1110 Healthway	Dr			10f. Zip Co	ode .804	4			10g. Citizen of USA		ntry?	
urs after deal at', or flarms Examiner m by Funer	11. Merital Stetus 1 Never Merried 2 Merrie 3 Widowed 4 Divorced	Armed Fe	2 [X No	1	Wes Deceden If Yes, specify	Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		ce - Americ ck, Whita, y: Wh		
ted tred	15. Decedent's	dent's Education 16a. Decedent's Usual Occu (Give kind of work done					ation	4	*	16b. Kind of B	lusiness/In	dustry	
12 should be filed within 72 ho is and Martal Hygiens. Is marked other than "natur fraumatic event, the Medical." To Be Completed	(Specify only highest Elementery/Secondery (0-12) 12		College (1-4or 5+) Homemaker					T OF WORK	ang .	Dome	stic		
	17. Father's Neme (First, Middle, Last) Jerome Whelpley Clara						First, Middle Smith		ne)				
nd 2 sho allty and M 27 Is man r traumar	19a. Informent's Neme/Reletionshir Suzanne F. Ers		ghter							er, City or Town		Code)	
Pages 1 areant of Health III (News)	20a. Method of Disposition 1 Burial 2 Cremetion 4 Donetion 5 Other (Sp.	20b. Plea	netery, crer	sition (Neme metory or other	of r plec	e)	12	Date 2/23/00	20c. Location White		ins, NY		
permit. Pages 1 Department of He important: if there any injury or oth otics.	21. Signature of Funeral Service L	**	M0105	22	Name end A HOLLOW	-				ofessior oury, MI		ssociation	
death certificate be executed e attending physician and ad for use as the burial-transit sician/Medical Examiner	shock, or heert feilure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. B b. fu c. Hen	Due to (or a	s a conseq	uence of):					mej	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Iriterval Between Onset and Death 2 w www 3 \ 7	
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7 si p	1 Yes 22 No	Hospitel:	Inpatient 2 E	VOutpatien	nt 3 DOA	Othe	er: 4□ Nu	ursing Ho	me 5 Resi	idence 6 🗆 Otl	her (Specil	y)	
Attending Ph or death. octor: After th by the funeral	27. Manner of Death 1 Naturel 5 Pending 2 Accident investiga		of Injury th, Dey Year)	8b. Time of Injury	28c.	Injury Work	vet k? Yes 2□		28d. Describe	how injury occur	rred		
tal or Attending P as after death. Indictor: After ted in by the funer led in by the funer Certification:	3 Suiside 6 Could not be							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Hospi 14 hour Funer tely fill	29e. Certifier (Check only one) Certifying 2 Medical E	caminer: On the b	best of my knowle asls of examinetion ner stated.	edge, deeth	occurred et to vestigation, in	he tim my op	e, dete en pinion, dee	d place, th occurr	and due to the red at the time,	cause(s) and m date and place,	anner as s and due to	tated. the cause(s)	
To the within 2 To the comple	29b. Signeture and title of certifier	28	401	~	29c. Li	cense	number 5	97	-	29d. Date signe	21 /26		
10	30. Name and address of person w Joseph Badros		se of deeth (Item 2 .3B Easte			• /	Salis	sbur	y, MD 2	21804			
State Registrar	31. Dete filed (Month, Day, Year) FEB 2 3 2		legistrer'a Signetur		Spar	V	,						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Marie Christine Ford MARCH 11 2000 5:15 AM 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LAPLATA CHARLES CIVISTA MEDICAL CENTER Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) November 10, 1940 Mary Land Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Days 1□M 20 F Months 59 220-42-3620 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 United States 9220 Sadie Lane 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Her Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Mae Keys Richard McCarthy Proctor 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Gloria Savoy/Niece Same as #10 20a. Method of Disposition f □ Burlal 2 □ Cremation 3 □ Removal from State 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State March 16, 2000 4 ☐ Donetion 5 ☐ Other (Specify) Zion Baptist Church Cemetery Welcome, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Maryland 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart limiter. List only one cause on each line. Approximete tntervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOVOLEMIC 1 DAY BLEED UPPER 61 Due to (or es a consequence of): PULMONALE YEARS Due to (or as a consequence of): HYPERTENSION ULMONARY YEARS 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes RENAL DISEASE STAGE

Physician /Medical Examiner

physician and s the burial-trans

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Box 68760.

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To the Hospital or Attanding PP within 24 hours after death.
To the Funeral Director: After th completely filled in by the funera

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

29b. Signature and title of certifier

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

MD

29c. License number D - 50350 29d. Date signed (Month, Day, Year) 03/11/00

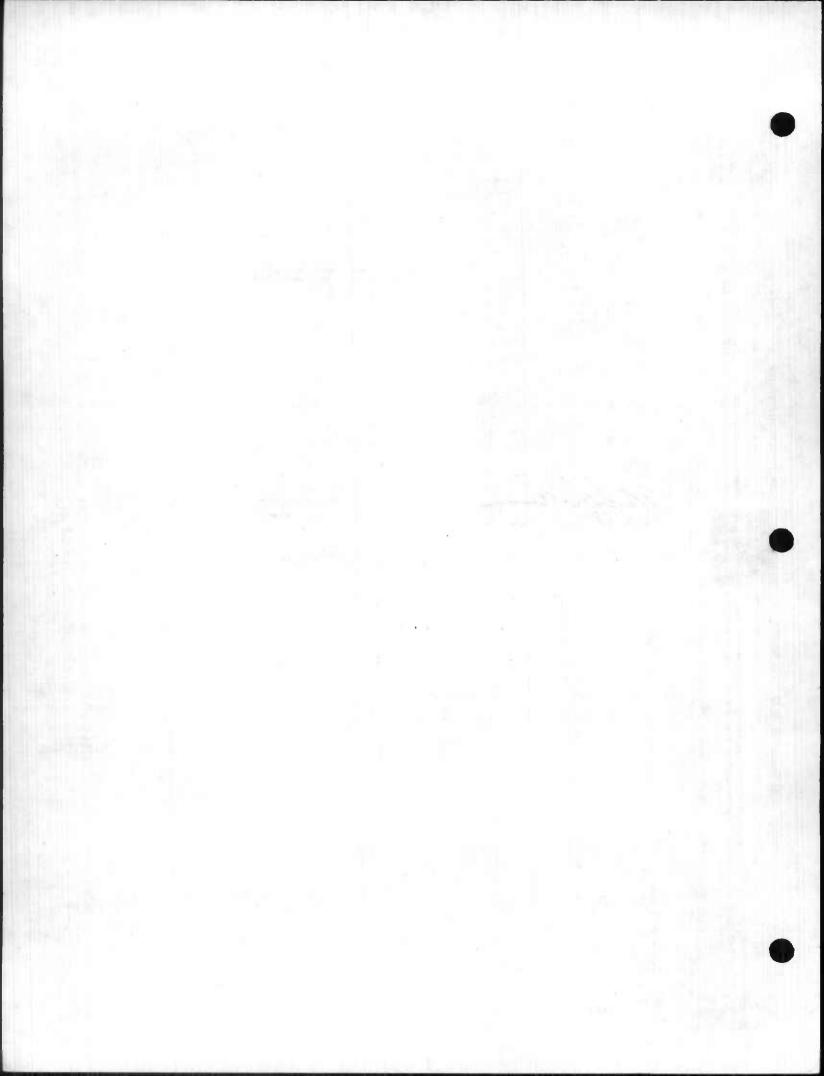
30. Nama and address of person who completed cause of death (ttern 23a) (Type, Print)

7C POST OFFICE RD. WALDORF, MD 20602 KRIGER FRANK MD 31. Date filed (Month, Day, Year)

State Registrar

MAR 14





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Year Phyllis Foster 03 03 00 17:45 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Manor Healthcare Center Rising Sun Cecil If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2\ F Months Days Hours Yrs. 86 Director September 1,1913Pennsylvania 213-52-8991 Usual Residence of Deceden the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show fraumatic avent, the Medical Examiner must be notified at t□ Yas 2FINo Director Rising Sun Cecil Maryland 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 Items 23a 1881 Telegraph Road 21911 United States Funeral 12. Was Decadant Evar In U,S. Armad Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Dataa: 14. Race - Amarican indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Pages 1 end 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. nt: If item 27 ia marked other then "natural", or ite 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 □ Yas 2 No Specify: White by 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usuei Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Education 12 Instructional Assistant 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surneme) Be 0 Samuel R. Keim Catherine Margaret Steuer 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Heelth a Important: If item 27 is any injury or other trace Susan F. Hall/Daughter 220 Ryan Drive, Rising Sun, Maryland 21911 20b. Placa of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burlal 2 Cremation 3 Ramoval from Stata March 8, North East Methodist Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) North East, Maryland 21. Signature of Funeral Sep. 22. Nama and Addrass of Facility Crouch Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. 127 South Main Street, North East, Maryland Onsat and Death **Physician** /Medical immediata Cause (Finel a Ling Cancer disaasa or condition rasulting in death) Llyeur Examiner Dua to (or as a consequence of): Examiner pue Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in deeth) Last Dua to (or as a consequence of): that the death certificate be execu physician Box 68760 Physician/Medical the Dua to (or as a consequance of) attending p Part II. Other aignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. P.O. ed by the detached 23b. Did tobacco use contribute to the cause of death? signed by t 1 | Yes 2 PNo 3 | Probably 4 | Unknown Records. ð been si 24b. Wara autopsy findings evaileble prior to completion of causa of death? 24e. Was en autopsy performad? Completed page 2 s 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific etaly filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) axaminar? Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Dev Year) 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? 5 Panding invastigation 1 Neturai 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 ☐ Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral DI completaly filled in 1 🗹 Cartifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 29a. Certifier edical (Check only one) 2 Madical Examinar: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Yaar)

3/7/00

D44373

101 Colonial Way, Rising Sun, Maryland 21911

State Registrar Weller

Joseph Weidner M.D.,

31. Date filad (Month, Day, Yaar)

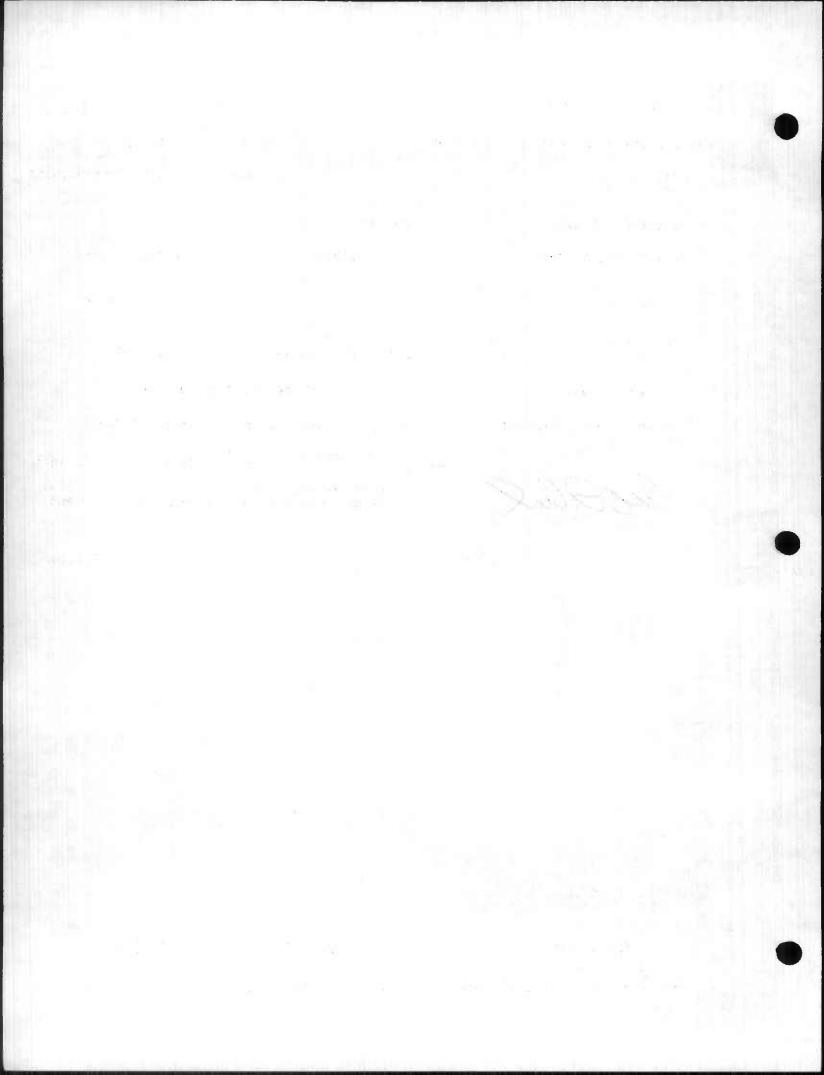
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eddrass of person who complated cause of death (Item 23a) (Type, Print)

32. Registrer's Signetura

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 09630 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Day **Physician** MARCH 4, DELMAS SAMUEL FIELDS 2000 01:21 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster
If Under 24 Hrs. 8 De Carrol1 5. Social Security Number 6 Sex If Under 1 Year 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 10M 2□ F Months Hours Director 50 216-52-556 Usuat Rasidence of Deced March 11, 1949 Maryland Pages 1 and 2 should be filed within 72 hours eftar daeth with the Maryland and chealth and Mental Hyglene.
Intil if Hear 27 le marked other than "natural", or Heme 23a or 28a-1 show may or other treumatic avant, the sec 10c. City, Town or Location 10a Stata al Hygiene. I dher than "natural", or Nema 23a or 28a-f ehow Ivant, tha Madrell Examinar must be notified at 10h County 10d. Inside City Limits 1☐Yes 2☐No Director Maryland Carrol1 Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Reaverton Avenue Funeral 21787 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No H Yes, Give Year or Datas: 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 Never Married 25 Merried Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) County Highways 9 Truck Driver 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) 8 Basil Densport Fields Myrtle Monroe 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 9 Reaverton Ave, Taneytown, MD 21787 Wonder E. Fields, wife 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata permit. Peges Department of Important: If It any Injury or o Burial 2 Cremetion 3 Removal from Stata 4 Donation 5 Other (Specify) Meadow Branch Cemetery Westminster, MD 21. Signature of Feneral Service Licenses 22. Name end Addrass of Facility 91 Willis Street Myers Funeral Home Westminster, MD 21157 23a. Parf1. Enter the disease, or complications that alused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause do leach line. Approximata Interval Between Onset and Death Physician /Medical Immediata Cause (Finat disease or condition resulting in death) ASCVO Examiner Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed physician and the burial-transit Sequentially tist conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): 9.8 for usa signed by the a P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed hss page certificata 1 Yas 2 No 1 ☐ Yas 2 No of Vital or Attending Physician: the funeral director. 25. Wes casa referred to medicat examiner? Certification: To Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1⊠Yes 2□ No 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Division 1 Natural 5 Pending invastigation To the Hospital or Attendir Within 24 hours effer death. To the Funeral Director: Al 1 ☐ Yas 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be Location (Street end Number or Rural Routa Number, City or Town, Stete) 28a. Plece of Injury - At homa, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, and due to the cause(s) and manner as stated.

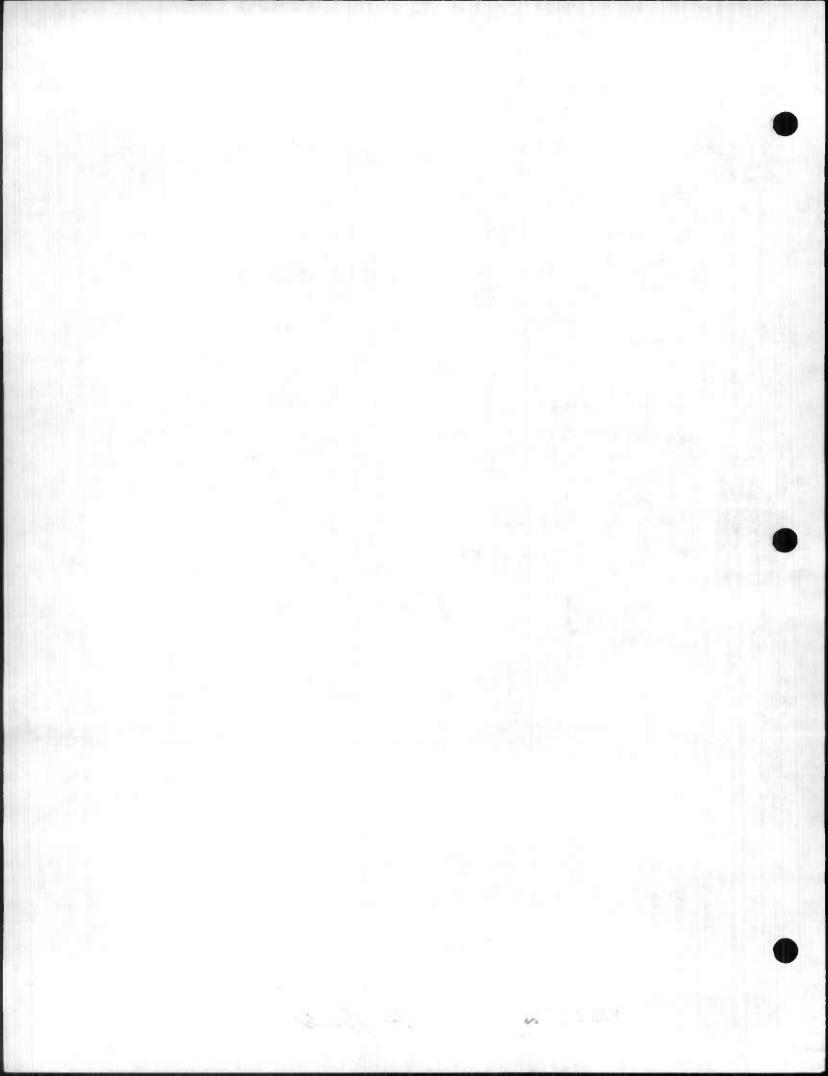
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. 29a. Certifier edical completely (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signeture end title of certifier 00051924 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) P. Henderson 295 Stoner Ave Suite 307 Westminster MD 21157 J- MO 31. Deta filed (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar

Caperais

MAR 0 6 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 09632. Certificate of Death 2. Dete of Deeth Day

Physician /Medical Examiner

Funeral Director with the Maryland

r than "natural", or itema 23a or 28a-f show the Medical Expriser must be notified at Hygiene. 7 is marked other traumatic event,

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be tile Department of Heath and Mental Hy, Important: if item 27 is marked othe any injury or other traumatic event, phose. Physician /Medical Examiner

and-trans death certificete be execu physician a s the buriel-80 USB signed by the a certificate has to irector, page 2 s this funeral ofter deetl Director: ŏ

P.O. Box 68760.

Division of Vital Records,

124 hours efter to Funeral Direct coletely filled in b To the Hosp within 24 ho To the Fune completely fi State Registrar

Medical

3. Time of Death 1 Decedent's Name (First, Middle, Last) Kenneth Fichtel March 3,2000 8:52AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Laurel Regional Hospital Prince George Laurel
If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2□ F Months Hours Min Yrs. 288-14-0353 Dec 29, 1918 Ohio Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 3 No Director MD P.G. District Heights 10e Street and Number 10g. Citizen of Whet Country? 7110 Gateway Blvd. 20747 Funeral United States 12. Wes Decedent Ever in U.S.
Armed Forces?

1XXYes 2 □ No
If Yes, Give
Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indien. 11. Mantal Status Bleck, Whita, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Accounting Technician U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) William Fichtel Bertha Hauff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aldona Fichtel (WIFE) 7110 Gateway Blvd. , District Heights, MD 20747 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

March 9, Da@000 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signeture of Funeral Servica Licensee Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Malignant Lymphoma 3 Years Due to (or as a consequence of): Examine Chronic Obstructive Pulmonary Disease 20 Years Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Thrombocytopenia Physician/Medical Due to (or as e consequenca of): Cirrhosis 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. XX Yes 2 No 3 Probably 4 Unknown Portal Hypertension by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed Right Plural Effusion completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 20 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 5 Pending Investigation 1 Yes 2 No

2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the fime, date and place, and due to the cause(s) end manner steted. (Check only one) 29c. License number

29b. Signature and title of cartifier an

D43330

29d. Date signed (Month, Day, Year) March 4, 2000

Pkay Greenhelt Md 20170

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREENE MO 7500 Dansver

31. Date filed (Month, Day, Year) MAR 0 9 2000 32. Registrar's Signature

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THE RESIDENCE OF THE PARTY OF THE PARTY.

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day 4:00 p.m. Edward James Grabis, Sr. March 13, 2000 4e Facility Neme (If not Institution, give street and number) 4b City Town or Location of Deeth 4c. County of Death 5830 Fenwick Road Charles Bryans Road If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) tXXM 2□F Months Days Yrs. 219-16-0305 April 30, 1927 Maryland Usuel Rasidenca of Decedant 10e. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5830 Fenwick Road 20616 United States 12. Was Decedant Evar in U,S. Armed Forces? 12 Yas 2 No If Yas, Giva Yaar or Datas: 1946 14. Race - American Indian, 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 Nevar Married 2 Married 1945-1 Yes XXNo Specify: p 3 Widowed 4 □ Divorced White 1946 16a. Decedant's Usuel Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) (Give kind of work dona during most of working life. DO NOT usa ratired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor D.C. Government 18. Mother's Name (First, Middle, Meiden Sumama) 17. Fether's Name (First, Middla, Last) Francis Joseph Grabis Anna Marie Stallman 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Thalia Ausherman/Daughter-in-law 6120 Fenwick Road, Bryans Road, Maryland 20616 20b. Piace of Disposition (Nama of cematary, crametory or other placa) March 17, 2000 20a. Mathod of Disposition XBurial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) St. Charles Cemetery Indian Head, Maryland 22. Neme and Addrass of Facility 21. Signatury of Fymeral Service Licensee Williams Funeral Home, P.A. MO0668 4270 Hawthorne Road, Indian Head, Maryland 20640 23a Part Entur ha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiretory arrest, Approximate Approximate Intarval Between Onsat and Death Immediata Cause (Finel disaasa or condition rasulting in daath) Noune Que o (or es a consequence of): Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disaase or Injury thet Initiated avants rasulting in daath) Last Doe to as a consequence of): Dua to (or as a consaquanca of): 23b. Did tobecco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy obestr 1 Yas 2 No 1 Tyes 2 No Nuad wed (a) 25. Was casa ratarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) side 1 Yas 2 No 27. Mannar of Daath 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding 1 Yas 2 No invastigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 4 Homicide

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permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If item Z7 Is marked othe eny Injury or other traumatic event page.

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(Check only one)

29b. Signature and the of conifier

Baltimore, Maryland 21215-0020

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32. Registrar's Signature Zens

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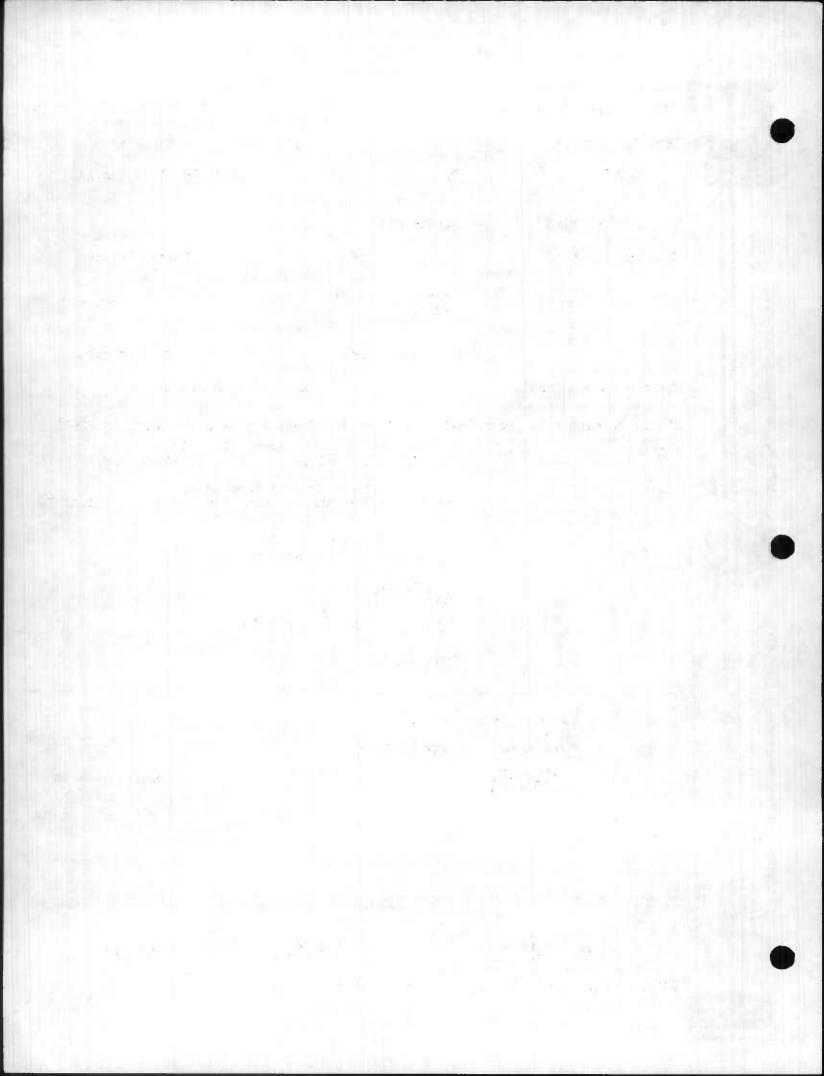
McCertifying Physician: To the best of my knowledga, daath occurred at tha tima, deta and place, end dua to tha causa(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated.

29c. License number

29d. Data signed (Month, Dev. Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 2 **Physician** Toni Renee Gordon 2:10 pm 24 2000 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Hours 10M 20F Months Days Min 579-78-8594 Yrs 43 **Director** D.C Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show trsumstic svent, the Modical Examinar numbe notified at MD 1 Yes 2 □ No P.G. Director Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7905 Lockney Avenue 20012 USA Funerai death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, atc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Introvantie if it is a 27 is merked other than "natural", or ite any injury or other traumatic event, the Medical Examenates. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 € Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 3 years Telephone Operator Communication 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Gordon Ruth Crowell Lemoine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 7905 Lockney Ave., Takoma Park, MD 20012
ca of Disposition (Neme of Date 20c. Location - City or Town, State Ruth Lemoine Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetary 3-2-00 Suitland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility James E. Vann Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Approximate Approximata Interval Between Onset and Death **Physician** Immediate Causa (Finat disease or condition resulting in death) /Medical Metastatic Carcinoma of Liver Examiner Due to (or as a consequence of) Examiner certificate be executed ician and burial-trans Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the Due to (or as a consequence of) USB as I the attending for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by Sepsis, Clinically Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Debilitated State page 2 2 ENO 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After Certification: 1 Natural 5 Pending Hospital or Attanding 24 hours effer death. Funeral Director: After 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide 24 hours 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical npietely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the ceuse(s) and manner stated. (Check only one) To the I 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number amporter M dram ned A. N D24593 2-24-00 M. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammed A. Mannan, MD., 3331 Toledo Terrace, Hyattsville, MD 20782 32. Registrar's Sigoatura 31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

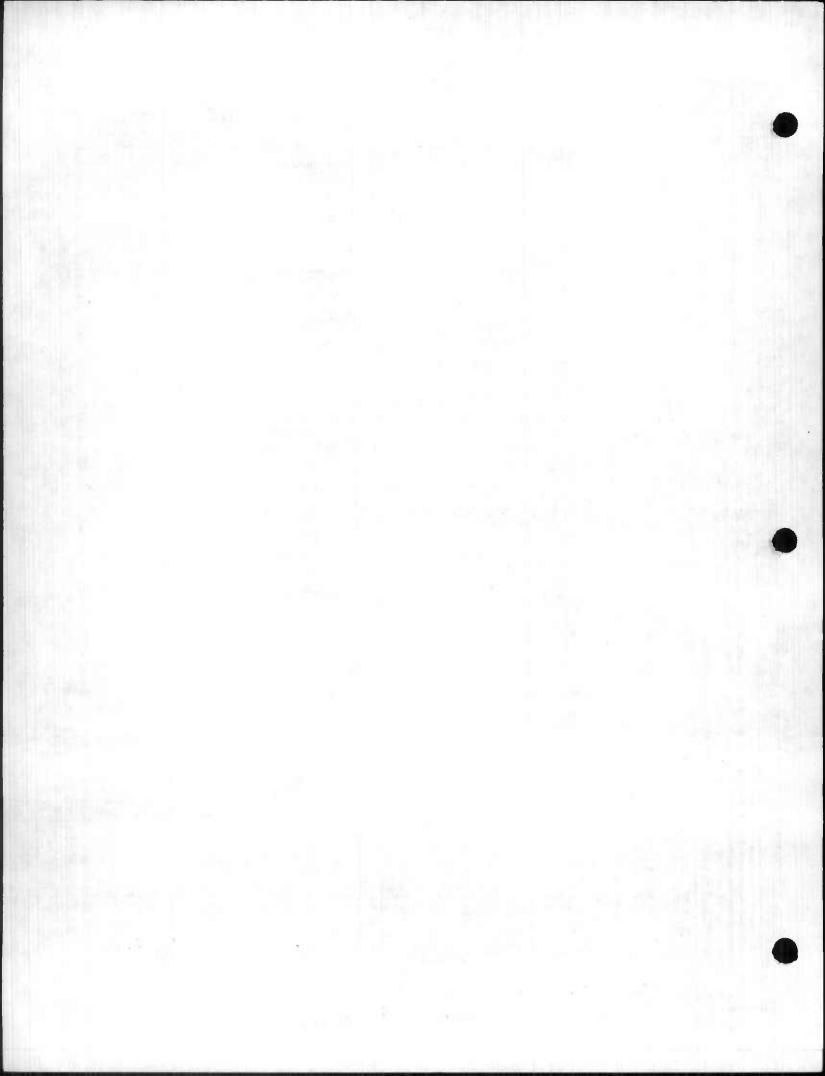
09635 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Des Month Year **Physician** MARIO FRANK GENTILE March 8, 2000 10:30 AM /Medical 4e Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Center, Genesis ElderCare Wicomico Salisbury, Md. If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In vrs. last birthday) If Under 1 Yaar 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□ F Yrs. 051-01-6311 82 Director April 18,1917 New York **Usual Rasidence of Decedent** with the Menyland 10e. State 10b. County 10c. City, Town or Location would 10d. Inside City Limits Maryland Wicomico Salisbury 1 Yes 2 □ No Director notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or flame 23s or the Medical Examiner must be 431 Monticello 21801 Ave. USA Funeral death 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - American Indian, Black, Whita, atc filed within 72 hours efter TYAS 2 No Army 1 Never Married 2 Married 21215-0020 1 Yas 2 No Specify: Specify: by White 3 Widowed 4 □ Divorced Year or Dates: WW II Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Correction Officer Correction 7 te marked other treumatic event, t aitimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) permit. Peges 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other treumatic event 8 Remo Gentile Antionette Spagna 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn A. Wieland/Daughter 519 S. Pinehurst Ave., Salisbury, MD 21801 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20s. Mathod of Disposition Data 1 Burial 2 Commation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Salisbury Crematory 3/9/00 Salisbury, MD 21. Signature of Funeral Service Licenses 22. Nema and Address of Fecility Holloway Funeral Home Professional Association CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Entar the disease, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiretory arrast shock, or heart failura. List only one cause on each lina. Approximate Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final Noumans disease or condition resulting in death) Examiner Physician/Medical Examiner Singe The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760, use as the Due to (or as a consequence of): ò P.O. I Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? should be detect 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Ware autopsy findings evailable prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? page 2 20 No 1 Yes 1 ☐ Yes 2 ☑ No certificate or Attending Physician: funeral director, 25. Was casa refarred to medical 8 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Rasidence 8 Othar (Specify) 1 Yes 2 No Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending invastigation 1 DNeturat s efter death. 1 Yas 2 No 2 Accident 100 6 Could not be 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 29a. Certifier edical completely within 2 To the 5 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 8 D-39813 ar cu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 44144 MICHAEL ATKINS, M.D. 1104 HEALTHWAY DR., SALISBURY, MD 21804 32. Registrar's Signatura 31. Date filed (Month, Day, Year)

State Registrar

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State of Maryland / Department of Health and Mental Hygiene 09636 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** Howard W. Green Feb 09 2000 12:35 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manokin Manor Princess Anne Somerset Hours Min. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1⊠M 2□ F July 5, 217-12-4589 91 Director MD Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1. Yes 2 No MD Directo Somerset Princess Anne 28a-1 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 11480 Beckford Ave. 21853 "natural", or thems 23a U.S. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Datas: Rece - American Indien, Bleck, White, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 Specify: Black 1 Yes 2 No Specify: å 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be fried will Department of Health and Mertal Hygien important: If flem 27 is marked other the arry injury or other traumatic event. the 3rd Laborer various 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 Mitchell Green Mary Hopkins 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Alice Matthews/daughter 11480 Beckford Ave., Princess Anne, MD 21853 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 2/10/00 Salisbury, MD 21. Signeture of Furieral Service License 22. Neme and Address of Fecility Lewis N. Watson Funeral Home 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediata Ceuse (Finel disease or condition resulting in death) Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? \$ 6 1 | Yaa 2 No 3 | Probably 4 | Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed peen s 1 ☐ Yas 2 No 1 ☐ Yas 2 ☑ No certificata Division of Vital 25. Was case referred to medical axaminer? 89 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral 쨷 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edicai 185 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the tima, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d, Deta signed (Month, Day, Year) 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801

DHMH 16 Ray 6/95

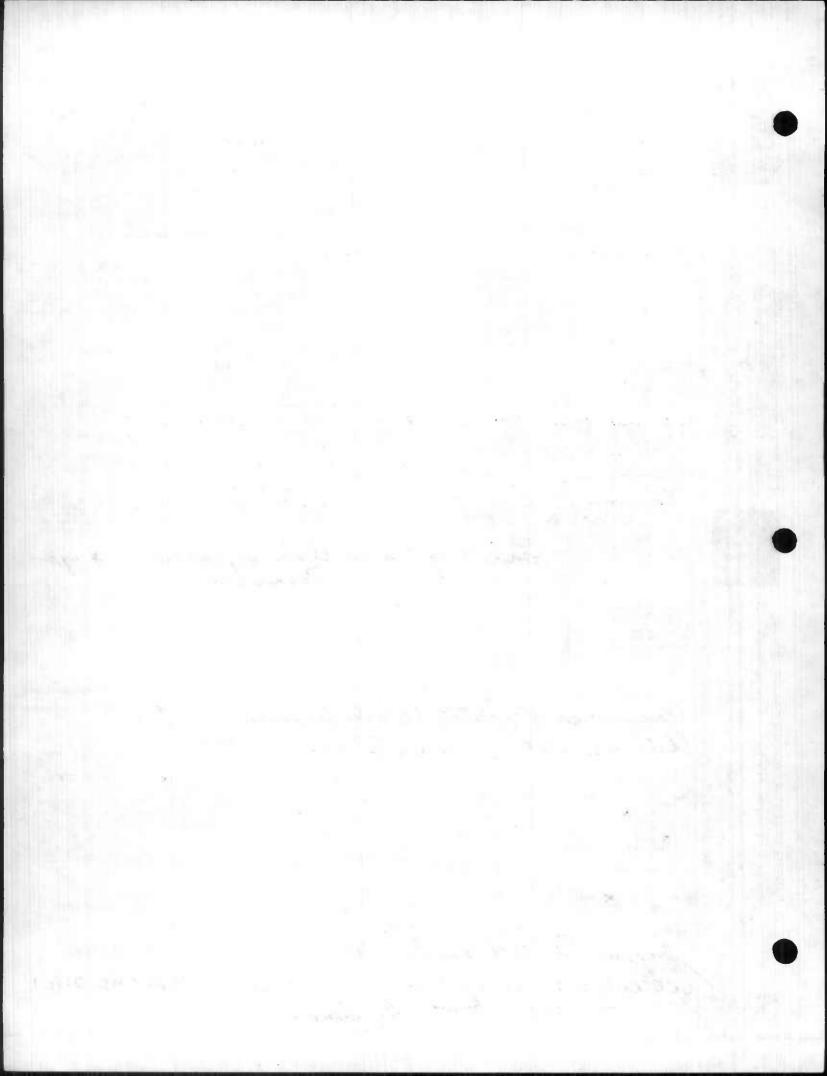
State

Registrar

31. Date filed (Month, Day, Year)

FEB 16

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09637 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month 2:15 PM GLADDING February 28,2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 100 E. Federal St Snow Hill Worcester If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 M 2 XF 93 Yrs. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 E. Federal St 21863 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William Shockley Cornelia Davis 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Cornelia Gillette/Daughter 908 Riverside Dr., Salisbury, MD 21801 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Burial 2 Cremetion 3 Removel from Stete Bates Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/2/00 Snow Hill, MD ure of Funeral Service Licens 22. Name end Address of Fecility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Point. Enter the disease, or complications that caused the doubth. Do not enter the mode of dying, such as cardiac or respiratory arrest, whoch, or heart feilure. List only one cause on each light Approximate Intervel Between Onset end Death Immediate Cause (Finel ACUTE CARDIO VOSCULAR ACCIDENT days

Physician /Medical Examiner

physician and s the burial-transit

To the Hospital or Atlanding Physician: The lew requires that the death certificate be associated within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlantinant

Division of Vital Records. P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

P

Completed

Be

10a. State

Maryland

11 Marital Status

disease or condition resulting in death)

Funeral

Director

ham 27 la marked other than "natural", or hama 23a or 28a-f ahow other traumatic avant, the Medical Examinar must be notified at

permit. Peges 1 end 2 should be filled within 72 hours after death v Department of Health and Mental Hygiena. Important: If fram 27 is marked other than "patural", or hams 23a any linjury or other traumatic avant, the sec

	Due to	or as a consequence o	1):				
	" HY DERTH	SIVE CA	RDIUVASCUA	R D1524525	15-78ABRS		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or es a consequence o					
Ceuse (Disease or injury that initiated events resulting in death) Last	Due to (or es e consequence of):				
Part II. Other significant conditions or	ontributing to death but not re	sulting in the underlying	cause given in Part I.	23b. Did tobacco use con	ntribute to the cause of death 3 Probably 4 Unknow		
				24a. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?		
				1 ☐ Yes 2 No	1 Yes 2 No		
25. Wes case referred to medicat			26. Plece of De	eth (Check only one)			
examiner? 1 Yes 284No	Hospitat: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ I	OOA Other: 4 Nursing F	Home 5 Residence 6 □Oth	er (Specify)		
27. Manner of Death 1 Neturat 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red		
3 Suicide 6 Could not be determined	28e. Place of Injury - At to building, etc. (Speci	nome, ferm, street, fectority)	281. Location (Street and Number or Rural Route Number, City or Town, Stete)				
				e, end due to the cause(s) and me urred at the time, date and place,			
29b. Signature and title of certifier	2	2	9c. License number		d (Month, Day, Year)		

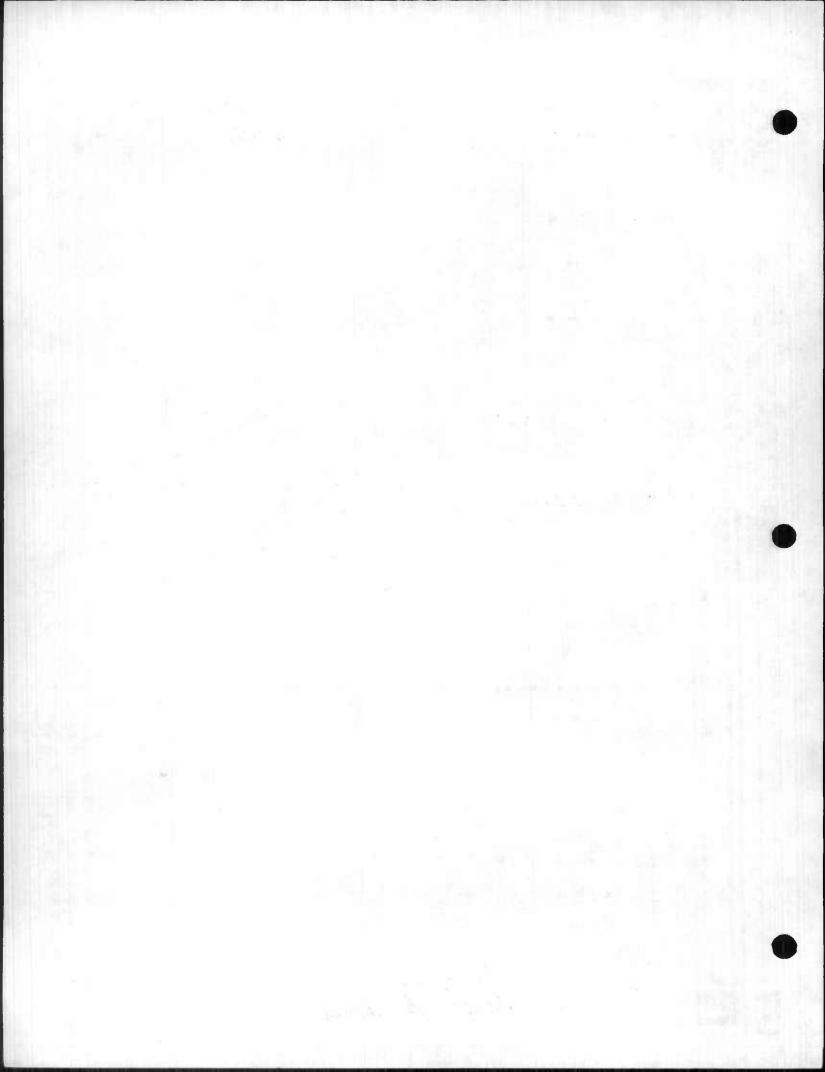
10 State Registrar

KUBERT 31. Date filed (Month, Day, Year) MAR 0 1 2000 LA MAR, 32. Fegistrar's Signeture

shift the on an MO

nd address of person who completed cause of death (Item 23a) (Type, Print)

104 N. BAY SNOW 1914, Mp 21863

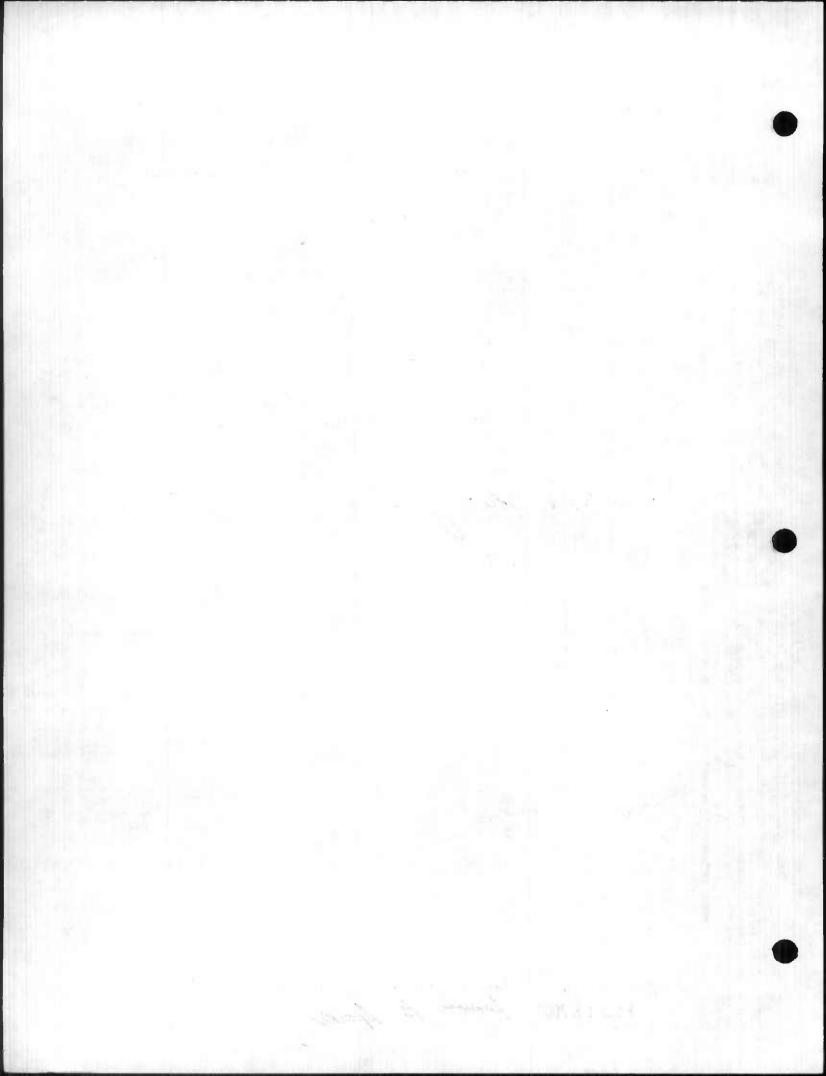


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** FREDERICK GOLDSCHMIDT February 17,2000 5:40 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine 619 Twin Tree Rd. Salisbury Wicomico If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 16,1911 Birthplace (State or Foreign Country)
 Maryland **Funeral** 1X M 2□ F Months Deys Hours 215-07-4521 88 Director Usual Residence of Decedent The Maryland 10a. State 10b. County 10c. City. Town or Location 10d. tnside City Limits Maryland Wicomico Salisbury 1 Yes 2 No Director notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be WITH 619 Twin Tree Rd. 21801 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☑ Merried 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 8 Mill Wright, Foreman Bethlehem Steel 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Goldschmidt Harry Mary Elizabeth Borleis 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a iff Item 27 is or other tra Josephine A. Goldschmidt/Wife 619 Twin Tree Rd., Salisbury, MD 21801 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any injury or pose. Parkwood Cemetery 2/19/00 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Name end Address of Fecility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Do not enter the mode of dying, such as cardiac or respiretory errest, Part 1. Enter the disease, or complications that caused the design about, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical condervasculor disease Atheroschrotic Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or es a consequenca of) Box 68760 physician Phyaician/Medical \$ th Due to (or as e consequence of) for use signed by the a d be detached f Part It. Other algorificant conditions contributing to death but not resulting In the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No After this certificate Division of Vital or Attending Physician: funeral director, 25. Was case referred to medicat 8 26. Place of Death (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 26b. Time of 28c. Injury et Work? 1 Naturat 5 Pending 1 Yes 2 No death. investigation Director: / 2 Accident the 6 Could not be determined To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifie 1)41721 02/17/00 30. Name and address person who completed cause of death (Item 23a) (Type, Print) OBOX49, SAlisbury PAUlos 31. Date filed (Mooth, Pay, Year) FEB 1 8 2000 State

DHMH 16 Rev 6/95

Registrar

Dack



Gough

State of Maryland / Department of Health and Mental Hygiene

09639 Certificate of Death 2. Data of Death 3. Time of the

Physician /Medicai Examine

1. Decedent's Name (First, Middle, Last)

John

March

2000 7:05 P.M.

05

Funeral Director

death with the Marylend

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Depertment of Heelih end Mentel Hygione. Important: if Item 27 is merked other than "neturel", or items 23e or 28e-1 show any Injury or other thaumatic event, if a Marical Evantmer mast be notified at

Baltimore, Maryland 21215-0020 **Physician** /Medicai Examiner

ettending physician end for use es the burial-trans Division of Vital Records, P.O. Box 68760, signed by

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funerel Director: After this certific filled in by

Be

Certification:

Medical

er	4a. Fecility Neme (If not institute Millennium Hea				n Ce	nter			own, or Location of De		County one		ndel
	5. Social Security Number 578-40-0621	6. Sex	7. Ag	ge (In yrs. last b	oirthday) Yrs.	If Under 1 Months I	Yaar Days	If Unda Hours	Min. B. Dete of (Month, Dec. 1	Birth Day, Year) 3, 19	30	Co	hplaca (State or Foreign unity) yland
	Usuei Residence of Decedent												
	10e. Stete 10b. Coun	ty		10c. City, To	wn or Lo	cation							10d. Inside City Limits
ctor	Maryland Ca	lvert			Pri	nce Fr	ed	erick					1 ☐ Yes 2 ☐ No
ire	10e. Street end Number					10f. Zip C	ode			10g. Citi:	zen of W	/het Co	untry?
aiD	95 Mason R	oad					20	678			US	SA	
by Funeral Director	11. Marital Status 1 Never Merried 2 M. 3 Widowed 4 Divorce	Evar in U,S.	ar in U,S. 13. Wes Decedent of If Yes, specify Cu					14. Race - American Indian, Black, Whita, etc. Specify: Black					
ted	15. Deced	ent's Education	- dl	16	e. Deced	dent's Usuel (Occuj	petion	at at constant	16b. Kli	Ind of Bu	siness/	Industry
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OB	Thomas			Goug	h			Maz	ie		Нε	rdn	an
-	19e. Informent's Name/Relatio	nship (Type, Print)			_	na Address (S	Street	and Numb	ber or Rurel Route Nur	nber. City o	r Town.	State. 2	Zip Code)
	John Gough, J					lason R			ince Frede				
	20e. Method of Disposition 1 Buriel 2 Crametion 4 Donetion 5 Other	n 3 □Removal fro	om State	cemet	ery, cren	sition (Name matory or othe Wester	er pia		Date cery3/14/00				Town, Stata erick, MD
	21. Signeture of Funeral Service Dlady a	e Licensae)			Neme end			26METT I				, MD 20678
	23a. Pert1. Enter the disease, shock, or heert feilure. Li Immediete Ceuse (Final disease or condition resulting in deeth)	or complications the st only one cause of e.	et caused in each li	the deeth. Done.		er the mode				y errest,			Approximate interval Between Onset and Death Moret Mau
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i Exan	Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury			Due to (or es									
Medica	thet initiated events resulting in deeth) Lest			Due to (or es e	o (or es e consaquence of):								
sician/	Pert II. Other eignificant condi	tions contributing to	death b	ut not resulting	in the u	nderlying cau	se gir	ven in Pert	i. 23b. D	id tobacco	use cor	tribute	to the cause of death?
y Phy	Preumo	onia							1	☐ Yes 2	□ No	3 🗆 Pi	robably 4 Unknown
Completed by Physician/Medical Examiner										es an eutoperformed?	osy	1	Were autopsy findings syelleble prior to completion of ceusa of deeth?
S									1[□Yes 21	No		1 ☐ Yes 2 ☐ No

30. Nema and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

Dealectrured, tois MAR 09

5 Pending investigation

6 Could not be determined

25. Wes cese referred to medical exeminer?

1 Yes 2 No

27. Manner of Deeth

Naturel

2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

Road. 32. Registrar's Signeture 2000

1 ☐ Inpatient 2 ☐ ER/Outpatient

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28e. Dete of Injury (Month, Dey Year)

Deale mp

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. Licansa number

3□ DOA

28c. Injury et Work?

1 Yes 2 No

D 50653

GYAN CHAND

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

20751

28d. Describe how Injury occurred

5'URAWA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signad (Month, Day, Year)

3-06-2000

State Registrar

Manager Comment Toward

State of Maryla

and / Department of Health and Certificate of Death		09	164	0
	2. Date of Death	3.	Tima of I	Death

Physi /Med		ESTELLE VIV	IAN	GUILKEY			Month March	Day 6 20	Year 00	8:53 p.m.		
Exam		4a. Facility Nama (If not institution, give	Statistics (Santa			4b. City, Town, o	r Location of Death	4c. County	of Death			
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Funera Directo	_	5. Social Security Number 6. S 492 12 0539	T. Age (In yr	rs. last birthday) Yrs.	Months Day					lace (State or Foreign try) Ouri		
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= 2 =		10a. Street and Number 7420 Marlboro Pik			10f. Zip Coda	20747	1	0g. Citizen of V USA	Vhat Coun	try?		
- e = E	Ď	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar In Armed Forces? 1 Yas 2 No If Yes, Give Year or Datas:		Was Decedent of Yas, specify Cu Yes 2☐Xi		(Specify Yas or No- erto Rican, etc.)	14. Race - Amarican India Black, White, etc. Specify: White		etc.		
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no age and o was a your		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Ramoval from Stata	Place of Dispos cemetery, crame tropoli	netory or other p	,		20c. Location -		wn, State Virginia		
Baltimo permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Licen		M11 22	. Name and Add	ress of Facility	ARSHALL'S	FUNERA	L HOM	IE		
		23a. Part1. Entar the disease, or comp shock, or heart failura. List only	plications that caused the de							Approximata Interval Between		
Physiciar /Medica Examine		Immediate Cause (Final disaase or condition resulting In death)	a d'aut	a. Acute Fatal arrhythmia 3mm								
De sis	liner		Due to	Under lying Corenary lettus Dis. 20 yrs.								
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	siclan/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest	c. Hup	(or es a consequ (or as a consequ	51 VE C	ardio	Vascella	en Di	5.2	eges.		
. 0 0 2	iclan/	Pert II. Other significant conditions or	ontributing to death but not re	esulting in the un	ndertving cause o	iven in Part I	23h. Did to	phacco use co	ntribute to	the cause of death?		
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v requ	Completed	Obstruct	ive Pulu	uonur	\$ 015	lase	24a. Was a parlor	in autopsy med?	ava	ore autopsy findings vilable prior to inplation of causa death?		
Vital Relicion: The lav	Com	Congestive	Heart	tail.	as 2 No	1 🗆	Yas 2□No					
- 5 00	o Be	25. Was cese retarred to medicel examiner? 1 ☐ Yes 2 ☑ No	Hospitat: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3□ DOA C	ther	eath (Check only or Home 5 ☐ Reside		er (Specify	()		
O E 5 E	ertification: T	27. Menner of Death 1	28a. Dete of Injury (Month, Dey Year)		28c. Inj		28d. Describe h					
Division or Attending after death. Director: Afte	ertific	3 Suicide 6 Coutd not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office	9	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)					

been signed by the attend should be detached for us Physician Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified Be P Certification:

1. Decedent's Nama (First, Middla, Last)

29a. Certifier (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

29c. Licansa number

29d. Date signed (Month, Day, Year)

death (Item 23a) (Type, Print)

12825 Old Fort Rd Ft. Wash, mg

State Registrar

Medical

31. Date filed (Month, Day, Year)
MAR 0 8 2000

MAR OF ROLL SAM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Year **Physician** emmel March 4 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Dayview Medical Center Baltimore Hopk ins If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex J. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 20 F 2 408-09-864 Sept. 26, 1917 California Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 18 Yas 2 No Crofton Md. Anne Arundel 10a Street and Number 10f. Zip Code 10g, Citizen of What Country? 21114 USA 1702 Gunwood Place Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black White etc. 1 Tas 2 No If Yas, Give Year or Datas: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Robert Edmondson Aileen Hazel Ridgeway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Gemmell 1702 Gunwood Place, Crofton, Md. 21114 0 20c. Location - City or Town, Stata 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 03-11-1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA. 21. Signatura of Funaral Sarvice Licensee 22. Name and Addrass of Facility Beall Funeral Home RODERT G. Beall M00025 6512 N.W Crain Hwy., Bowie, Md. 23a. Part1. Entar the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20715 Approximete Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 200 No 1 Yas 25. Was casa refarred to medical axaminar? Be 26. Place of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA Medical Certification: To Memar of Death 28d. Describe how injury occurred 28b Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida

Division of Vital Records, P.O. Box 68760, or Attending Physician:

The law requires that the death certificate be asscuted

Funeral

Director

28a-f show

r than "natural", or frame 23e or 28e-f the Medical Examiner must be notified

death with the Maryland

filed within 72 hours after

Hygiene.

Pages 1 and 2 should be in nent of Health and Mental I int: If Nem 27 is marked or

= 8 permit. Page Department of Important: If eny injury or page.

Physician /Medical

Examiner

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the bunal-transit

been signed by the attending p should be detached for use as

page 2 :

funeral director,

filled in by

certificata

After this

21215-0020

Baltimore, Maryland

within 24 hours after death. To the Funeral Director: A \$ 0

Hospital

State Registrar

ANTONIA 31. Data filed (Month, Day, Year)

MAR 0 7 2000

29b. Signature and title of certifier

29a. Certifiar (Check only one)

30. Name end address of person who complated cause of death (Item 23a) (Type, Print) BUNC

Johns 32. Registrar's Signature

12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Bayview Medical Center

199 1990 Burney B species 1991

Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's Hyattsville 10c. City, Town or Location Hyattsville 10d. Street and Number 4109 Kennedy Street 10d. City Town or Location Hyattsville 10f. Zip Code 20781 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yas 2 No No Specify: 1 Yas 2 No Specify:	nery thiplace (State or Foreign ountry) New York 10d. Inside City Limits 1 🖁 Yas 2 🗆 No
Muriel Joan Grimes 4a Fecility Nama (if not institution, give street and number) Washington Adventist Hospital 5. Social Security Number 216-30-4249 1	th mery thplace (State or Foreign ounly) New York 10d. Inside City Limits 1 🖁 Yas 2 🗆 No
Washington Adventist Hospital Takoma Park Montgom 5. Social Security Number 216-30-4249 I	nery thplace (State or Foreign ountry) New York 10d. Inside City Limits 1 🖁 Yas 2 🗆 No
5. Social Security Number 216-30-4249 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Prince George's Hyattsville 10e. Street and Number 4109 Kennedy Street 11. Marital Status 12. Was Decedent Ever in U,S. Amed Forces? 11 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16. Sex 17. Age (In yrs. last birthday) 65 Yrs. 10. Location Months Days Hours Min. Marital Status 10c. City, Town or Location 10c. City, Town or Location 10d. City Town or Location 11d. Specify Cuban, Maxican, Puerto Rican, etc.) 11d. Race - Ameder Maxican, Puerto Rican, etc.) 11d. Race - Ameder Maxican, Puerto Rican, etc.) 11d. Yas 2 No Specify: 11d. Yas 2 No Specify: 11d. Specify only highest grade completed) 11d. Location 11d. Race - Ameder Maxican, Puerto Rican, etc.) 11d. Yas 2 No Specify: 11d. Race - Ameder Maxican, Puerto Rican, etc.) 11d. Race - Ameder Maxic	thplace (State or Foreign punity) New York
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18. Mother's Name (rirst, Middle, Last)	ndustry
P 7 11.	
E. Franklin Holton Doris Edna Heintz	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2	
William Grimes - Son 171 Chesapeake Mobile Court, Hanover, MD	
20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location · City or cematary, crematory or other place)	Town, Steta
4 Donation 5 Other (Specify) Fort Lincoln Cemetery 3/9/2000 Brentwood	, Maryland
21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, M. 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,	MD 20781 Approximata Interval Batween
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or es a consequence of): Due to (or es a consequence of): C. Due to (or es a consequence of): Due to (or es a consequence of): 1 Due to (or es a consequence of):	
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute	
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24a. Was an autopsy performed?	Wera autopsy findings available prior to completion of cause of deeth?
1 ☐ Yes 2 ☑ No	1 Yes 2 No
25. Was case referred to medical , 26. Place of Deeth (Check only one)	
examiner? 1 Yes 2 No Hospital: A paper 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Special Properties)	ecify)
27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of In	
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yas 2 No 28c. Describe how injury occurred 28d. Desc	s stated.
and manner stated.	
296. Signature and title to certifier 29d. Dataysigned Month 5 29c. License number 29d. Dataysigned Month 349/08	n, Day, Year)
30. Name and address of person who completed cause of pieth (Item 23a) (Type, Print)	
Raymond Nwadiuko, M.D., 9831 Greenbelt Road, #101, Lanham, MD 20706 31. Data filed (Month, Day, Year) 32. Registrar's Signature	

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death		Reg. No.	0 03040		
	Decedent's Neme (First, Middle, Last)	2. Date of Dea Month		3. Time of Death		
Physician /Medical	William Wallace Gallahan	March 8		5:37 PM		
Examiner	4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Li	ocation of Death	4c. County	of Death		
	Southern Maryland Hospital Clinton		Prince	e Georges		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 227-34-2399 7. Age (In yrs. last birthday) Months Days Hours Min.	8. Date of Birt (Month, Da) Oct.22	h y, Year) 1023	9. Birthplace (State or Foreign Country) Sharpersville,		
niector	Usual Residence of Decedent	000.22	1723	bliat persvirae,		
MON III	10a. Stele 10b. County 10c. City, Town or Location			10d. Inside City Limits		
to to	Maryland Prince George's Clinton	1 ☐ Yes				
red ired	10e. Street and Number 10f. Zip Code		Vhat Country?			
23a or 28a-f show ust be notified at rai Director	12323 Piscataway Road 20735		USA			
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Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "naturn any injury or other treumatic avent, me Medical once. To Be Completed	8 Faint Foreman		1.0. 00	. Belious bysee		
		ame (First, Middle, Meiden Surneme)				
	William Brandt Gallahan Marjori	e France	es Middl	.eton		
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rus	al Route Numbe	er, City or Town,	Stete, Zip Code)		
	June V. Gallahan/Wife Same as item 10					
	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		City or Town, State		
	MXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Mary's Church Cemetery	3/13/20	000 Cli	Inton, Md.		
	21. Signature of Cineral Septical Licenses 22. Name and Address of Facility George P. Kalas Fu	- D /				
FEE	Hy Calas George F. Ratas Fu 6160 Oxon Hill Rd.					
	23a. Pekt. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart tallure. List only one ceuse on each line.			Approximate		
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d by the attending letached for use Physician/M	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part t.			ntribute to the cause of deeth?		
gned by the attendin be detached for use by Physician/A	CON688 TIVE HEART PAICURE	10	Yss 2□ No	3 □ Probably 4 □ Unknow		
should should	RENDE FACURE	24a. Was perfo	24b. Were autopsy findings available prior to completion of cause of death?			
is certificate has director, page 2 To Be Comp	CAMPIAC BRICK & THMIA	10	Yes 24 No	1 ☐ Yes 2 ☐ No		
ertifica ector.	25. Was case referred to medical 26. Place of Dear	th (Check only o	ne)			
0 G 0	examiner? 1 Yes 2 No Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing He	ome 5 Resid	dence 6 Oth	er (Specify)		
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Within 24 hours siter death. To the Funeral Director: After thi complately filled in by the funeral Medical Certification:	1 Protural 5 Pending (Month, Day Year) Injury Work? 1 Yes 2 No 1 Yes		ation (Street and Number or Rural Route Number, or Town, State)			
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o the	29b. Signature and title of certifier 29c. License number		29d. Date signe	d (Month, Day, Year)		
3 F 8	Don D 9. Lee, MD D 15789		3-9-			
1101	20 Alexandra de la constitución	6- 4	1			
10/	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)	110	2 7	35		
	270270	NO	101			
State	31. Date filed (Month, Day, Year) 38. Registrar's Signature					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

			Cer	tificate of	Death		Re	g. No.	U	1964	4
	1. Decedent's Neme (First, Middla, Last	0	10.00	53.10			2. Date of Death Month	Day	Year	3. Tima of De	eath
Physiciar /Medica	llestrad ('Ottleton	Hanco ck					February			2:00	PM
Examine	An Physilian Manny Mines Institution of the	street and number)			4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
60	Anne Arundel Medi					apoli		Anne			
Funeral Director	5. Social Security Number 6. Se 213-48-0289	7. Age (In yrs. 51	last birthday) Yrs.	Months Days		Min.	8. Date of Birth (Month, Day, Jan. 24	, 1949	9. Birthol Coun Mar	lace (State or F try) yland	Foreign
land m	10a. Stete 10b. County	10c. Cr	ty, Town or Lo	cation					10	0d. Inside City	Limits
Ra-f sh	MD Anne Aru	indel	Annapo	7				1□ Yes 2	!□No		
15-0020 72 hours after death with the Meryland 7 natural; or thems 23s or 28s-f show 60s-standing must be notified at	2817 Mockingbird	Ct.			21401			lg. Citizen of V	SA		
	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forceş? 1 ☐ Yes 2 ὧ No If Yes, Give Year or Dates:		Ves Decedent of I Yes, specify Cut I ☐ Yes 2☐XNo			cify Yes or No- Rican, etc.)		e America k, Whita, o	etc.	
1 21215-0020 led within 72 hours af ygiene ar than "nertural; or rt, the Modela Extern Commission by 8	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occu	during mos	t of workii	na 1	6b. Kind of Bu	usiness/Ind	lustry	
	Elementery/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	ed)						
d 2 filled v filled v	17. Father's Neme (First, Middle, Last)	4	Insu	rance Re	-		Ve (First, Middle, M	Insui			
should be filed of Mental Hygi marked other imatic svent, I						Coulter	arcon connen	.0,			
Maryland d 2 should be file th and whentel Hy treumatic svent To Bac	19e. Informent's Name/Relationship (7)		19b. Mailin	g Address (Stree			Route Number,	City or Town,	State, Zip	Code)	
and 2 and 2 a saith a 27 le	James W. Hancock, I	II / brother	427	14th St			Ocean Ci			1842	
or Health	20a. Method of Disposition	206. [Place of Dispos	sition (Name of natory or other pla		1		Oc. Location -			19,719
Pages nent of int: if its	1 ☐ Burlel 2 ☐ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)	demover from State				3-	2-00 B1	ren two	d. Me	d.	
Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if frem 27 is marked other than eny injury or other treumatic svent, the Monte.	4 Donetion 5 Other (Specify) Ft. Lincoln Crematory 3-2-00 Brentwood, Md. 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral 147 Duke of Gloucester St. Annapolis, MI										
	23a. Pert1. Enter the disease, or complete	lications that caused the deal							lls,	MD 2140 Approximete) [
Physician	shock, or heart feilure. List only o	ne cause on each line.		,						Intervel Betwee Onset and De	en ath
/Medical	trimediate Cause (Final disease or condition									Rlyn	
Examiner	disease or condition resulting in death) a								1		•
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68760, licate be executed physicien end is the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								7	0	
50, be ear	cause. Enter Underlying Cause (Disease or Injury	den	anc o	The commence of					year		
t 68760, difficate be en ng physicien es the buria	thet initieted events resulting in death) Last	Due to (c	or as a connect						-1. 240		
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P.O. BO) hat the death ce d by the strendi seteched for us. Physician	Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did tobacco use contribute to the cause of deal			
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aw requir sy been s 2 should	Climi	ic Otria	P'Sil	ni1100	jar	1	24a. Wes an perform		SAS	ere autopsy find allable prior to impletion of cau death?	
Vital Re- Idean: The lay certificate has rector, page 2							1 TYes	s 2 No	1 [Yes 2 N	0
Of Vita Physician: r this certific and director,	25. Wes case referred to medical				26. Place	e of Deeth	(Check only one	9)			
Physic this call direction To	1 Yes 2 No		ER/Outpatien	1 3LI DOM		-	ne 5□ Resider			y)	
Division of Vital bal or Attending Physicien: The State death. The Director: After this certificat ed in by the funeral director, page Certification: To Be Co	27. Manner of Death 1 Meterrel 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. tnju			28d. Describe how	w injury occur	red		
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Or A	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
ours ours filled filled	29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wieden death	occurred at the t	ime date an	d place a	and due to the car	use(s) and ma	nner as st	ated	
he Hospit in 24 hour he Funer pletely fill	(Check only 2 Medical Exami	ner: On the besis of examina end manner stated.									
Division of Vital Re To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29b. Signeture of title of certifier		110 5	29c. Licen	se number			d. Date signe	1		
	Type (toman	-	D	OJ:	310	1	2128	100)	157
	30. Name and address of person who or	ompleted ceuse of death (Item FULATORS U		Print) S Pi	dgel	y R	rae 1	Inno	pale	is, MD	امهال
State Registrar	31. Date filed (Month, Day, Year) MAR 0 3 2000	32/Registrar's Signa	d.	Spark	W	1					

DHMH 16 Rev 6/95

and to the

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

Decedent's Name (First, Middle, Last) SUZANNE)		ertificate of	Dealii	-	2. Date of Deat	ng. No.		3. Time of Death
SUZANNE						Month	Day	2000	3:40 P.
a Facility Neme (If not institution, give s	HARRIS street and number)			4b. City, Tow	m, or Loc	ation of Death	4c. Count	y of Death	(0
North Arund	1 1 11	tal	4 - 4/1	Glen	BI	urnie	An	ne A	rundel
Social Security Number 6 Sex	7 Ann (h vrs	last birthday	Months Devs	If Under 2	2	8. Dete of Birth (Month, Dey,	Year	9. Birthp	lace (State or Foreigns)
217-05-3261D	м Ж Ж⊧ 85	Yrs.	Months Days	nouis		JUNE 2	0 191	4 VII	RGINIA
Jsual Residence of Decedent 0e. State 10b. County	10c C	ity, Town or L	ocation					1	0d. Inside City Limit
								1	1X Yes 2 □ N
MARYLAND ANNE A	RUNDEL E	PASADI	10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
8241 OLD MILL	ROAD		21122				og. Omzon o	USA	,.
	12. Wes Decedent Ever in U	J,S. 13	. Was Decedent of H	lispanic Origi	in? (Spec	cify Yes or No-		ce - Americ	
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No		If Yes, specify Cub		Puerto F	tican, etc.)		ack, White,	
XIXWidowed 4 □ Divorced	If Yes, Give Yeer or Detes:	10.	1 ☐ Yes ZÃ No	Specify:			Speci	іђ: БЫ	ACK
15. Decedent's Educ (Specify only highest grade	cetion	16a. Dec	edent's Usual Occup	ation during most	of workin		16b. Kind of E	Business/Inc	dustry
Elementery/Secondery (0-12)	Cottege (1-4or 5+)	life.	DO NOT use retired	d)			-		
12th	0	H	OUSEWIFE		la Nome	/Einst Adiabate *		NE	
7. Fether's Name (First, Middle, Last)	NCON					(First, Middle, METTA G			
1100000	INSON	10h 14-1	ling Address (Street						Code
19e. Informent's Neme/Relationship <i>(Ty)</i> ARBARA HILL (DA	UGHTER)		OLD MIL						
Oa. Method of Disposition	20b.	Place of Disp	position (Name of				20c. Location		
1 ☑ Burial 2 ☐ Cremetion 3 ☐ R	Removel from State M1	cemetery, cre	RIDGE M	ce) IEM - F	K .	3/4/00	ELKE	RIDGE	, MD.
4 ☐ Donation 5 ☐ Other (Specify)			22. Name and Addre			-, -, -			
7/ann 17	Leens		M. REESE	& SC	DNS				
23a. Part1. Enter the disease, or compli	. / <					POLIS,		2140	1 Approximate
resulting in deeth)	Due to (Or as a const		UMO					
disease or condition resulting in deeth) Sequentially list conditions, ferry, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events esulting in death) Last	Due to (Due to (ANG		equence of): PAU equence of):			110N			
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esulting to deeth) Sequentially list conditions, I eny, leading to Immediate sause. Enter Underlying Cause (Disease or thjury hat initiated events esulting in death) Last	Due to (or as a conse	equence of): advance of): advance of):	INF		23b. Did to 1 4 Y	n autopsymed?	3 Prof	bably 4 Unknown
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Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or trijury hat initiated events resulting in death) Last 25. Was case referred to medical examiner? 27. Manne of Death 1 Neturet 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	Due to (Due to (Due to (Due to (Due to (or as a consection or as a conse	equence of): aquence of): equence of): underlying cause give ent 3 DOA Otto of 28c. tnju M 1 Dogstreet, factory, office ath occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation, in my office of the occurred at the timestigation at the occurred at the occurred at the timestigation at the occurred at th	26. Plece ner: 4 \(\text{Nur} \) Nur y at k? Yes 2 \(\text{Nur} \) Nur, dete end upinion, deeth	of Death sing Hon 2 loo 2 l plece, e	23b. Did to 1 V 24a. Was a perior 1 V (Check only on the 5 Reside Red. Describe hower the control of the cont	n autopsymed? es 20 No es 20 No es 20 No es 6 00 ow injury occu treet and Nun n, State) euse(s) and n ate and plece	3 Prof	ere autopsy finding allable prior to impletion of cause deeth? Yes 2 No
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State Registrar

Physicial /Medica Examine

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hygiene.
Important: If item 27 is merked other than "natural", or items 23s or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at posse.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours stated death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

SUZANDE

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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Physician	6 Per Phy. 2 1. Decedent's Neme (First, M	iddle, Last)				2. Date of Dea	Day Ye	3. Tima of Death
V.	/Medical	Nannie	Elizabe		iggens		February	1 24 20	
	Examiner	4e Facility Name (If not institute North Arunde)		oer)		Glen Bur			runled Conty
	Funeral Director	5. Social Security Number 215: 05.45%	6. Sex 7.	. Age (In yrs. lest bird	hday) If Under 1 Yee Months Dey	or If Under 24 Hrs.	8. Date of Birth (Month, Day Feb 1,	1 1880	Birthplace (State or Foreign Country) V. Virginia
P		Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Towr	or Location				10d. Inside City Limits
Maryle	of the Po		nne Arundel	Glen E					1 ☐ Yes 2☐ No
death with the Maryland	r from 23a or 23a-f showning must be notified at	10e. Street and Number 1110 Castle H		10g. Citizen of What Country?					
5-0020 72 hours after deat	ar, or he	3 Widowed 4 □ Divor	If Yes, Give	es? No	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spuber, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race - Bleck, 1 Specify:	American Indian, White, etc. White
22 Pe 72 Pe	natur oceal	15. Dece (Specify only his	dent's Education ghest grade completed)	16a.	Decedent's Usuel Occ (Give kind of work don	e during most of work	ing	16b. Kind of Busin	ess/Industry
2121 d within	ygiene. er then "naturn rt, the Medical Completed	Elementary/Secondary (0-1		lor 5+)	Seamstress			Clothing	
	d other event, is	17. Father's Name (First, Mide				18. Mother's Nam		Meiden Sumeme)	
/an/	Mental Briked officev	Snyder G. Ma	rtin			Est	ella Bl	anche Gru	iber
Maryland	Is me	19e. Informant's Name/Relet							ote, Zip Code) 21060
č	m 27 her tr	Beatrice C. K	night/ daugh		10 Castle Disposition (Neme of	Harbour Wa	y, Unit	1C, Glen	Burnie, MD
Imore,	ment of h	20a. Method of Disposition 1 Burial 2 Cremeti 4 Donation 5 Othe	on 3 Removal from St r (Specify)	ate cemeter	y, cremetory or other p	1	Peb 28 2000	Hagersto	
1	nysician Medical xaminer	23a. Part. Enter the objects abook, or heart failure. Immediate Ceuse (Final disease or condition resulting in death)	to complications that can be called an early one of the called an early one	th line.	of enter the mode of d	netary 1	or respiratory ar	rest,	Approximate interval Between Onset and Deeth
mound	n and sal-transit Examine	Sequentially list conditions, if any, leading to immediate	C . Prog	Due to (or as a	consequence of):	ortic	- \	212on	11 9000
68760, licate be e	Dong Ta	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events	. Cov	bus to (or as a c	ive k	teart	Fail	, 200	
	9 5 9	resulting in death) Last	d. Con	- CO NOW		Lary	Dise	on	4 years
de at	e ette	Part il. Other significant cond	ditions contributing to deal	th but not resulting in	the underlying cause	given in Part t.	23b. Did 1	obacco use contri	bute to the cause of death?
s, P.O.	been signed by the attending should be datached for use a: leted by Physician/Mo					1 Yes 2 No 3 Probably 4 Unk			
I Records, P.O. Box The law requires that the death certi	cate has been signate bage 2 should b						24a. Was perlo	an autopsy med?	24b. Were eutopsy findings available prior to completion of cause of deeth?
H Ball	page 2						101	res 2 No	1 Yes 2 No
Vital	director, page	25. Was case referred to med examiner?				26. Place of Dea	th (Check only o	ne)	
		1 Yes 2 No	Hospital: 1 ☐ Ing	patient 2 ER/Ou	tpatient 3 2 00A			dense 6 Other	
On Bulb	th. After this funeral d	1 Metural 5 □ Pe			njury V	vork? □ Yes 2 □ No	EUG. Describe	iow injury occurred	
DIVISION OF	is after death. of Director: After to the in by the funeral Certification:	3 Suicide 6 □ Co	uld not be ermined 28e. Place of building	×8	28f. Location (S City or Tox	Street and Number vn, Stete)	or Rural Route Number,		
To the Hospital	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifier (Check only one)	fying Physician: To the bacal Examiner: On the bas and menne	is of examination and	, deeth occurred at the d/or investigation, in m	tima, dete and place, y opinion, death occur	end due to the red at the time,	cause(s) and mann dete and place, and	er as stated. If due to the cause(s)
To the	To the comp	29b. Signature end fittle of	Uliac h.	Attend	rng 29c. Lice	onse number		29d. Date signed (
		flower.	men my	Physi	city DI	4228		02-2	
		30. Name and address of per-	ohnson 1	ND.	Type, Print) Swit	timore	ma	2122	8
	State Registrar	31. Date filed (Month, Dey, Yo		gistrer's Signeture	. Soork	6			

DHMH 16 Rev 6/95

Elizabeth Higgens

Nanne

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Paul February 28 2000 4:45 PM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) 6. Sex 1 → M 2 → F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 20, 10 5. Social Security Number 7. Age (In yrs. last birthday) Days 89 Yrs. 1910 Ohio 277-07-6372 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 1002 Boucher Ave. IISA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 N Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Real Estate Real Estate Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) "Unknown" "Unknown" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Boucher Ave. 21403 Olivia V. Heddleson / wife Annapolis, MD, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 3-3-00 Annapolis, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 alus 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) tensio Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mentel Hydene. Important: If item 27 is marked other than "natural", or home 23e or 28a-f show any lighty or other traumatic avent, the Wedies Examples must be nother as any lighty or other traumatic avent, the Wedies Examples must be nother

altimore, Maryland 21215-0020

Physician/Medical Examiner the signed by the þ Completed Be Medicai Certification: To

Hospital or Attanding Physician: The law requires that the death certificate be asscuted

certificate

this

After

24 hours after death.

within 2. To the Complet

tely filled in by

P.O. Box 68760,

Records,

Division of Vital

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 1 2 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

Forest Drive Amanalis.

State Registrar

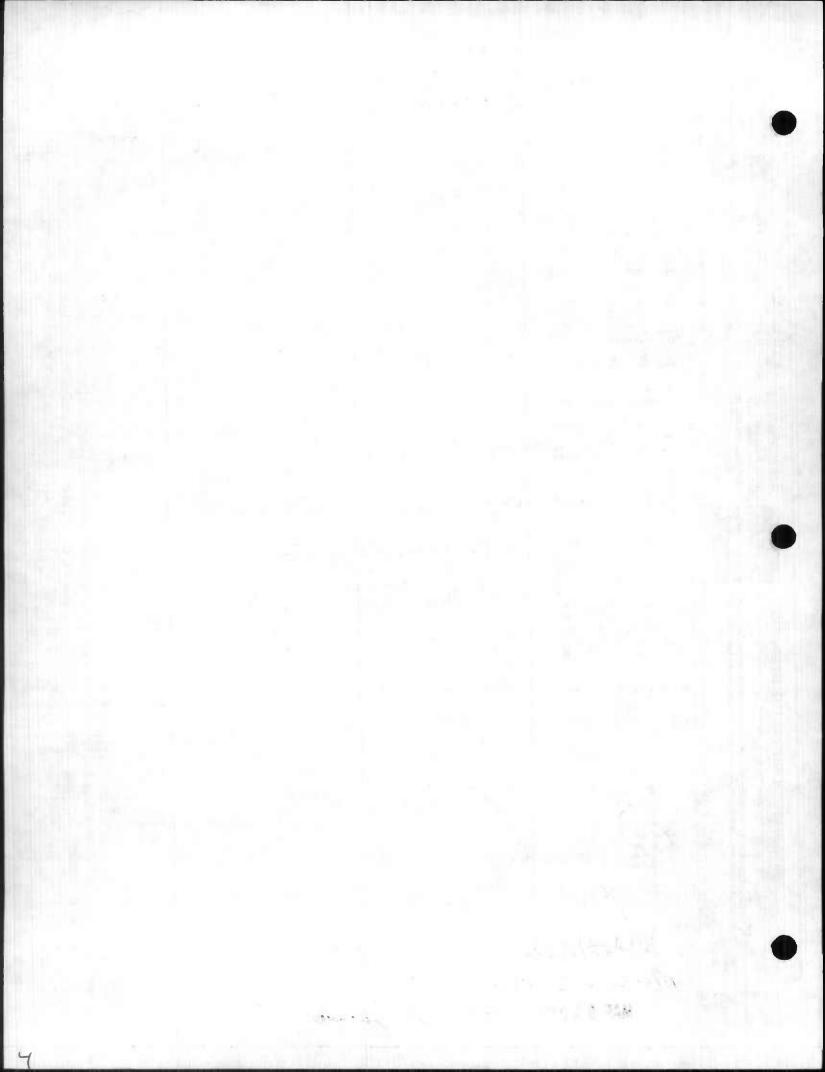
31. Date filed (Month, Day, Year) MAR 0 1 2000

29b. Signature and title of certifie

Ma 169 32. Registrar's Signature

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

18



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09668 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day AMY HUTTON FEB. 28 2000 8:00 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 701 GLENWOOD ST. APT.315 ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 28 F Months Days Hours Min. Yrs. 215-34-9823 26 1916 MARYLAND FEB. **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits 1 Yes 2 □ No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 glenwood street apt. 31

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 21401 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No Specify: Specify: BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th DOMESTIC PRIVATE HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BLAINE THOMPSON ETHEL ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLYDE QUEEN (NEPHEW) 900 SPA RD. APT 1 ANNAPOLIS, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Perial 2 Cremation 3 Removal from State MARYLAND VETERAN 3/3/00 CROWNSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry WM. REESE & SUNS FIGURES. MD. 21401

821 WEST ST. ANNAPOLIS, MD. 21401

Approximate Interval Between Onset and Death Lees WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work?

physicien end the burief-transit Box 68760, signed by the at d be detached for P.O. Records, Deen page 2 Pas a certificate Division of Vital this or Attending Pilester to Director: After to

Physician

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Examiner

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r than "natural", or hama 23s or 28s-f ahor the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "nat eny injury or other traumatic event, the Median one."

Physician /Medical

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Maryland 21215-0020

Baltimore,

an/Medical Physici by Completed Be Certification:

Examiner

Natural 5 Pending investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

29c. License number

29d. Dete signed (Month, Day, Year)

3

andol

30. Name and address of person who completed cause of death M A 83 18

31. Date filed (Month, Day, Year) MAR 02

29a. Certifier

State Registrar

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Medical

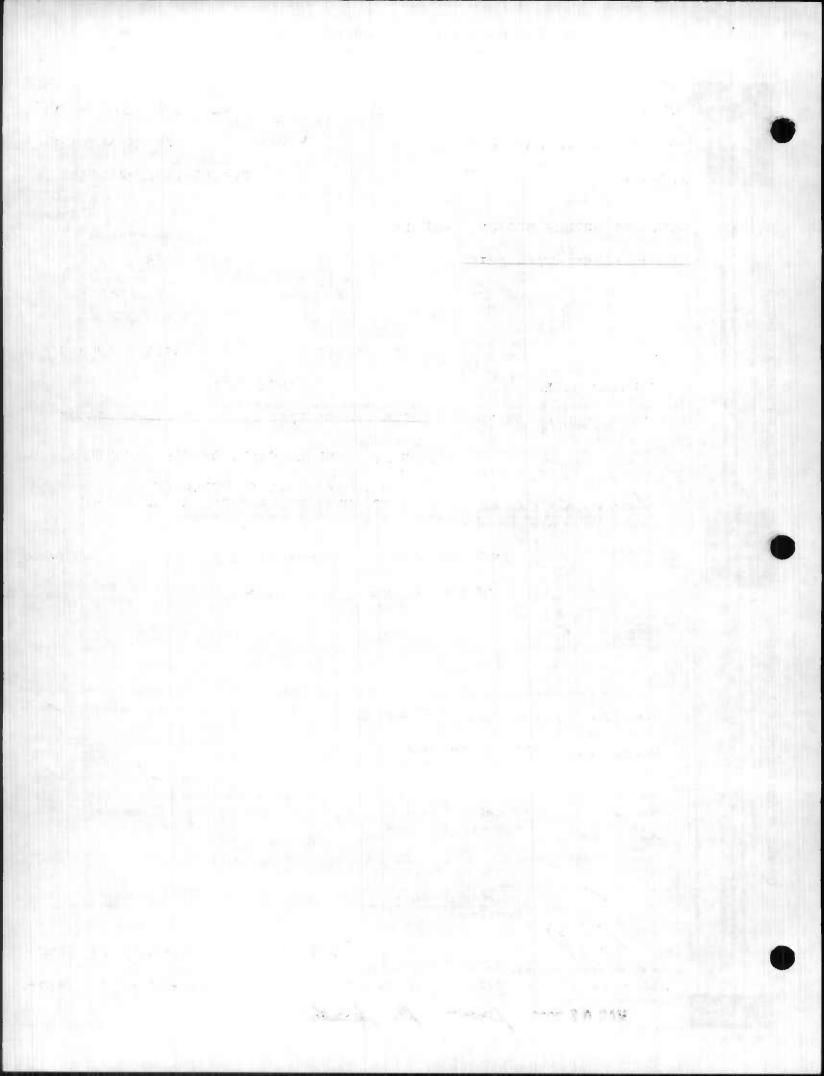
• Funeral C Hospital

To the Hosp within 24 ho To the Fune completely fi

MAK 0 2 2000 James John James

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AACO HEALTH Certificate of Death AMEND: #10e & 19b 3/16/00 mcg 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 0945 4a Fecility Name (If not institution, give street end number) Howard 02 00 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Laurel Prince George Laure 1 Regional Hospital 7. Age (In yrs. lest birthdey) If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Deys Hours Min Yrs. Director FEB.16 1938 MARYLAND 217-34-7846 Usual Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Directo LAUREL MARYLAND PRINCE GEORGE 10f. Zin Code 10g. Citizen of What Country? 109 Straight Number WALK DRIVE death Funeral 11536 LAUREI WALK DRIVE 20708 Was Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Maritel Status permit. Pages 1 end 2 should be filed within 72 hours after Department of Health end Mental Hygiene. Important: If item 27 is merked other than "naturel", or itel any hiury or other traumatic event, the Medical Examinate once. 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER DAISY BROTHERS 9th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) SADIE HOWARD WILLIAM OUEEN 19e. tntorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 11536 LAUREL WALK DR LAUREL, MD 20708 11539 LAUREL WALK DRIVE LAUREL MD 20708 20b. Place of Disposition (Name of cametery, crematory or other place) EVELYN K. HOWARD (WIFE) 20e. Method of Disposition XXBuriei 2 Cremetion 3 Removal from State WILSON MEM. CHURCH CEME. 3/2/00 GAMBRILLS, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility WM. REESE & SONS MORTUARY, P.A. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 821 WEST ST. ANNAPOLIS, MD. 21401 Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting In death) /Medical 48 HOURS INTRACEREBRAL HEMORRHAGE Examiner Due to (or es e consequence ot): Examiner HYPGRTENSIVE EMERGEN LY certificate be executed physician end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): 88 USB 23b. Did tobacco use contribute to the cause of death? Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown DIABTES MELLITUS TYPE Z Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed DIABETIC RETINO PATHY certificate has b lirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case reterred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA funerel 27. Manner of Deeth 28e. Date of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending efter death. Director: Aft 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour. the Funeral Direction of the filled in by 6 4 Homicide 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edical (Check only one) 29b. Signature and 196 of partifier, 29c. License number 29d. Date signed (Month, Day, Year) D39629 FEBRUARY 27, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALEXANDER SY MD 10724 LITTLE PATUXENT PARKWAY COLUMBIA MD 21044 31. Dete tiled (Month, Day, Year) 32. Registrer's Signeture MAR 0 2 2000

Registrar



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C.V. CYRIAC. MD, 8109 RITCHIR HWY, PASADRNA, MD 21122	P 8		Wywac s	10 Atter	ding	Doct	Y Z	2168	34	3 - / -	200	oy, Year)						
State 31. Dete filed (Month, Day, Year) 32. Begistrer's Signeture	State		O. I. Oete filed (Month, Dav. Year)	2 8-10	deeth (Item	TCH (1)	Z HWY	, PASI	ADENA	MD	2110	22						

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State of Maryland / Department of Health and Mental Hygiene 09651 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Deeth Month March 5, 2000 **Physician** Hund tenry 9:40 pm /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number 4b. City, Town, or Location of Death Examiner Millersville Anne Arundel 270 Glenda Court 8. Date of Birth (Month, Dey, Year) Dec 6, 1927 If Under 1 Yeer | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F 206-20-1493 72 Dec 6, Director Pennsylvania Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ahow MD Anne Arundel Millersville 1 ☐ Yes 2€ No Funeral Director 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of Whet Country? death with 6 21108 270 Glenda Court USA 238 | Nems 12. Was Decedent Ever in U,S. Armed Forces? 1 D Yes 2 □ No If Yes, Give Year or Detes: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Married 21215-0020 6 WWII 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Maryland State Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Lottery Representative Lottery Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked of Barbara Beri Frank J. Hund 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if them 27 is or other tra 270 Glenda Court, Millersville, MD 21108 Ethel L. Hund / wife Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Mar 8 20c. Location - City or Town, State 1 St Buriel 2 Cremation 3 Removation State 4 Donation 5 Other (Specify) Crownsville, MD MD Veterans Cemetery 2000 21. Signature of Fungral Sery by Licery 22. Name end Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Onset and Deeth **Physician** Immediate Causa (Final disease of condition resulting in death) /Medical Cholangio carcinama 3 months Examiner Examiner To the Nospital or Attending Physician: The law requires that the death certificate be associated within 24 hours state death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Whiknown Division of Vital Records, Completed by 24b. Were autopsy findings sysilable prior to 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 ONO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 1. Netural 2 Accident 26a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury st Work? 28d. Describe how injury occurred 5 Pending investigetion 1 Tyes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) anire ween, MD D52830 March 7, 2000 30. Name end siddress of person who completed cause of death (Item 23a) (Type, Print) Road, Sut 300, Annapolis, Mp 2140/ 900 Bestgate Jeanine Werner 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

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Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4c. County of Death FEBRUARY Patricia Ann Harris /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) Examiner CHEVERLY HOSPITAL CENTER PRINCE GEORGES PRINCE GENERALS Birthplace (State or Foreign Country) If Under 1 Year 6 Sev If Under 24 Hrs. 8. Dafe of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1□M 200 F Months Days Hours Min 577-56-3830 58 June 9, 1941 Director Washington DC Usuai Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 1 ☐ Yes 2 ☐ No Director Washington D.C. 10f. Zip Code 10e. Street and Number 10g. Cifizen of What Country? 213 M Street SW 20024 USA death y Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 1 t. Maritel Status Black, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 X Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mentel Hygiene. Elementary/Secondary (0-12) Coitege (1-4or 5+) Dietitian 10th Private permit. Pages 1 and 2 should be file Department of Health and Mentel Hyg Important: If Item 27 is marked other any injury or other traumatic event, page. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Lest) Ernest Mobley Laura Mosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ernestine Otey / Sister 213 M Street Washington D.C. 20024 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Forest Hills 3-7-2000 Clinton Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica Licensee J.B. Jenkins Funeral Home 7474 landover 8d Landover RD 20785 (1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** ARTERIOSCUEROTIC CARPIOVASCULAR DISEASE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner the death certificete be executed and I-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of) physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 80 attending p 23b. Did tobacco usa contributa to the causs of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown that signed b by law requires 24b. Were autopsy findings available prior to should Completed 24a. Was an autopsy performed? completion of cause of death? certificate hes birector, page 2 s The H 1 Yes 2 No t □ Ves 2□ No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Lo 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending 1 Netural hin 24 hours efter death. the Funeral Director: Al mpletely filled in by the fu 1 Yes 2 No death. 2 Accident Investigation 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, streef, factory, offica building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) within 2 To the F

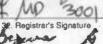
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of death

Olom 23a) (Type, Print)

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29d. Date signed (Month, Dey, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PAUL E. HANSBERRY FEB. 12:15 AM 27, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY COUNTY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR. 27, 1928 5. Social Security Number 9. Birthplace (State or Foreign WASHINGTON, DC 7. Age (In yrs. last birthday) **Funeral** Days 10XN 20 F Months Hours 71 578-34-4965 Director Usual Residence of Decedent r 28a-f ahow 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits D.C. N/A WASHINGTON 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 14 INGRAHAM ST. N.W. 20011 UNITED STATES Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?

XXX Yes 2 \(\) No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 72 hours after (X) ever Married 2 Married "natural", or to 1952 21215-0020 1 Yes 2 No Specify: by SpecifyAFRO-AMERICAN 3 ☐ Widowed 4 ☐ Divorced Al Hygiena. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 ment of Heelth and Mental Hyglens. Int: If Itam 27 le marked other than "riny or other traumatic avent, the Hed College (1-4or 5+) Elementary/Secondary (0-12) FROM MILITARY 12TH DISABLED Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY HANSBERRY LILLIAN LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THADDEUS HANSBERRY/BROTHER 14 INGRAHAM ST. N.W., WASHINGTON, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Durial 2 Cremetion 3 Removal from State permit. Page Department of Important: If I any Injury or MARYLAND VETERANS CEM. MAR. 07, 2000 CHELTENHAM, MD 4 Donation 3 Other (Specify) 22. Name and Address of Facility DUDLEY FUNERAL HOME MT. RAINIER, MD 3200 RHODE ISLAND AVE., 23a. Pert1. Enter the disease, or complications that caused the death. On the enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 1 day Branary Examiner Due to (or as a consequence of) Examiner The law requires that the death certificete be assecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physiclen the buriel Box 68760. Physician/Medical Due to (or as a consequence of): 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings Completed 24a. Was an autopsy performed? available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Affer 5 Pending investigation Division or Attending 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completaly (Check only one) 94 29d. Dete signed (Month, Day, Year) 2 - 28 - 2000 29c. License number
D 45660 N 124, Bocie MD 20216 of person who completed cause of death (Item 23a) (Type, Print) 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 6 2000

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State of Maryland / Department of Health and Mental Hygiene 00 0551.

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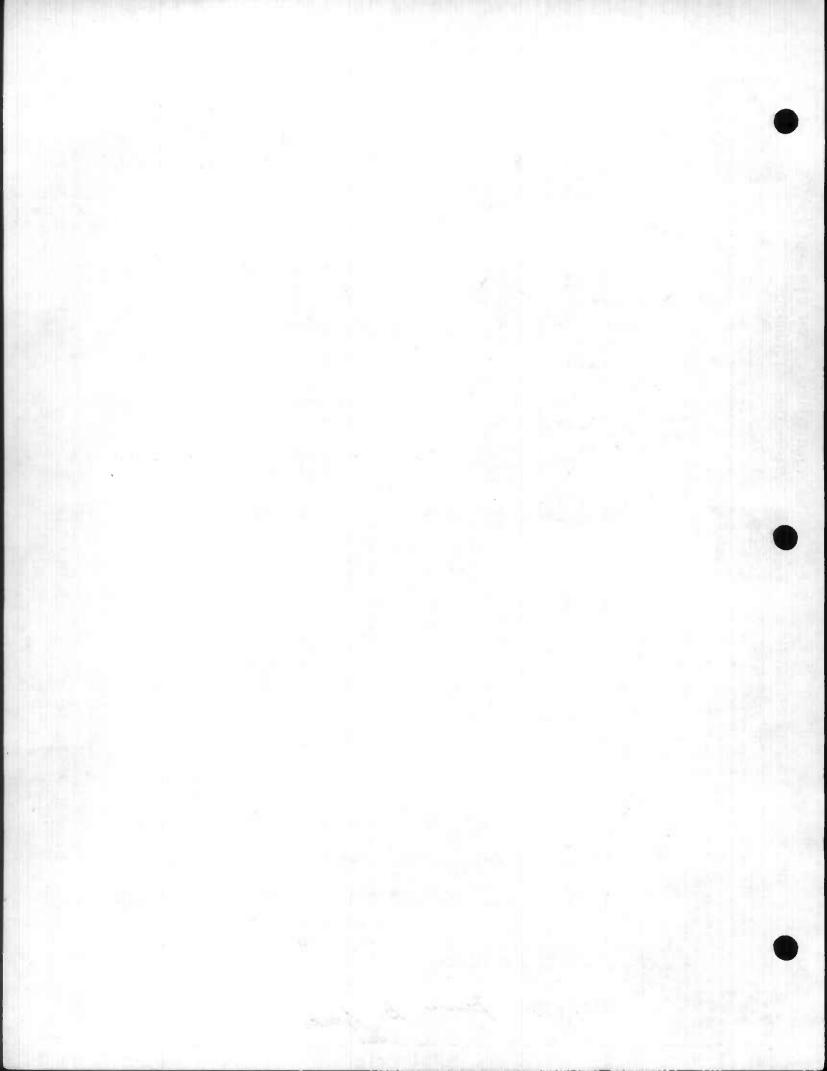
DHMH 16 Rav 6/95

SS# 219-05-3409 Louise Hall

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Division of Vital Records, P.O. Box 68760,		E
2	Division of Vital Records, P.O. Box 68760,	describe or Attending Provident The law requires that the death caddings he asserted

	Decedent's Name (First, Middle, Last,)		OCIL	ificate of	Death	2. Data of De	Reg. No.		3. Time of Dea		
an	Louise Hall						March	Dey	Year	0022		
al er	4a Facility Name (If not institution, give	Location of Dear	th 4c. County									
	PENINSULA REGIONAL MEDICAL CENTER SALISBU							WICO	MICO			
ī	5. Social Security Number 6. Sec	7M -	(In yrs. last I		If Under 1 Year Months Days		. (Month, D	rth ey, Year)	Country	ce (Stele or Fo		
	Usual Residence of Decedent	JW SML	95	Yrs.			Jan.1	1 1905	Virg:	inia		
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tor	Maryland Wicomi	ico	Sal	isbu	rv					1 Yes 2		
Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country	17		
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Funeral		12. Was Decedent E Armed Forces?		13. Wa	as Decedent of I Yes, specify Cub	Hispanic Origin? (5 san, Mexican, Puer	Specify Yes or No to Rican, etc.)	0- 14. Rad Ble	ck, White, etc			
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Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5-	+)	(Give ki	nd of work done O NOT use retire	pation during most of wo id)	nking					
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8	17. Father's Name (First, Middle, Last)							, Maiden Sumen	ne)			
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	21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility											
	1 England	26.	4	Ste	ewart 1 West	Funeral Rd.Sal	Home	,Md.218	301			
	23a Part1. Enter the disease, or combine shock, or heart failure. List only or	cations that caused- ne cause on each line	ever pleasen. Do	not enter	the mode of dyi	ng, such as cardia	c or respiratory	errest,	- Ir	pproximete nterval Betwee Onset and Dea		
	Immediate Cause (Final disease or condition		preum	nonice								
_	resulting in death)	(Due to (or as	a conseque	ence of):							
Examiner		0	Demen									
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BUNMODIC			conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of			
ysiciarymedic	Part II. Other eignificant conditions con	ntributing to death but	t not resulting	in the und	lerlying cause gi	von mir ant i.		1 Yes 2 No 3 Probably 4 DU				
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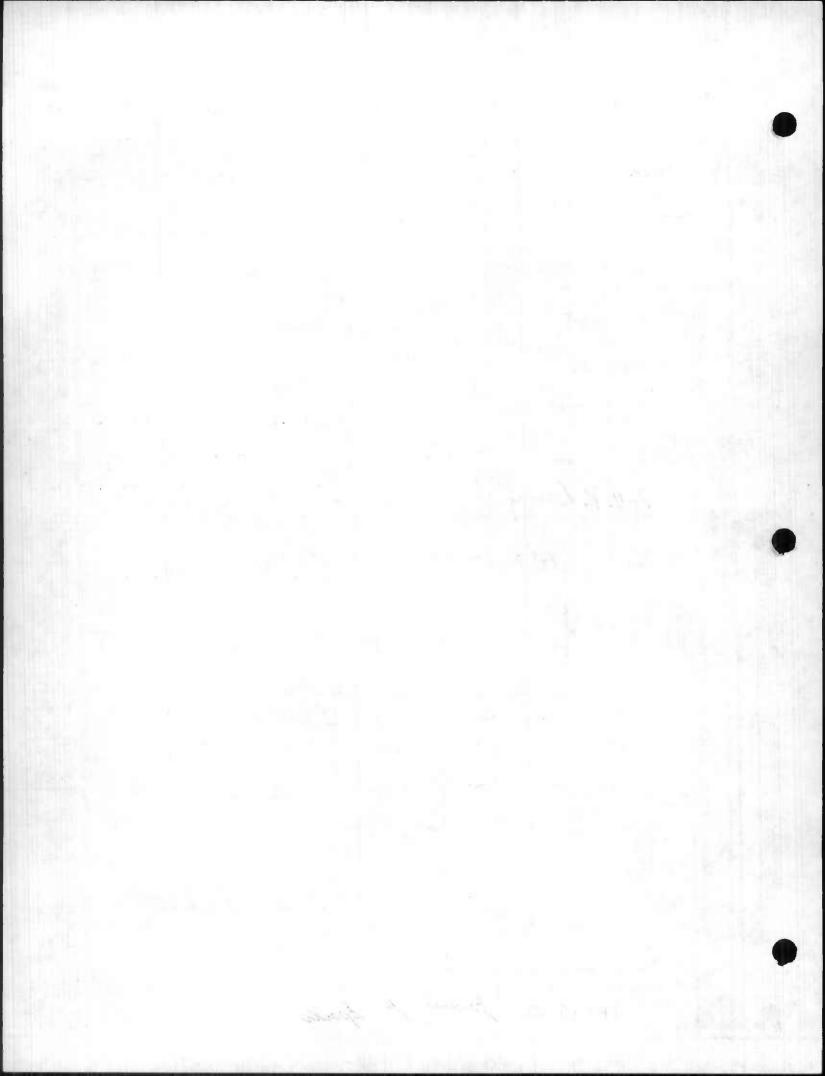


Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** FRANCES ADELI. HINDLE February 12 2000 4:12 am /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 F 231-52-6566 60 April 8,1939 Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No Wicomico Salisbury Director 280-71 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8 710 Outten Rd. 21804 USA 11 Maritai Status 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Yes 2 No
If Yes, Give Yeer or Detes: 1 Never Married 2 Merried ò 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Raymond T. Priest Emma Brown Estes 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John C. Pugh Jr./Son 56-1 Hawthorne Dr. North, New London, CT 06320 of Health Dam 27 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State Pages 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Springhill Memory Gardens 2/17/00 Hebron, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signeture of Funeral Service Licensee Atrinle 501 Snow Hill Rd., Salisbury, MD 21804 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Due to (or as a consequence or): Tungs, Timer and Vagina 2 yrs disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician the buria 68760 Physician/Medical Due to (or es e consequence of): Box (- esn 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2回 No 3 Probably 4 Unknown signed l þ Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? After Division 1 Netural or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) gern 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 GREGORIO M. BELLOSO, MD: 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Dete filed (Month, Dey, Year) FEB 15 2000 State Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Feb 23 2000 Clara E. Hart 1250 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) Birthpiece (Stete or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 X F Yrs. 222-05-0476 78 Director April 21,1921 DE Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show is marked other than "natural", or flams 23s or 28s-1 shor traumstic event, the Medical Examinal must be notilised 1X Yes 2 □ No Worcester Directo Berlin 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10208 Old Ocean City Blvd. 21811 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indian, Bleck, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ₩ Widowed 4 Divorced 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Clerk 12th Social Services 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) and Mental John Andrews Audrey Long 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is William Andrews/son 10101 Germantown Rd., Berlin, MD 21811 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Burial 2 Cremation 3 Removal from State Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Antioch A.M.E. Church 2/26/00 21. Signature of Funeral Service Licegate 22. Name end Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) NEUMONIA Examiner Due to (or as e consequence of) Examiner HEART Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequenca of) 1ETASTATIC Physician/Medical Due to (or es e consequença of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 NUnknown signed by þ 24b. Were eutopsy findings eveileble prior to 24e. Was en eutopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No conflicate 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1□Yes 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Sunpatient 2 ER/Outpatient 3 DOA 岩 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide within 24 hours To the Funeral edical Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated. Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, end due to the end manner. Saled. minetion end/or investigation, in my opinion, death occurred at the time, dete and plece, end due to the cause(s) ã Signature appr 29d. Date signed (Month, Day, Year) 00

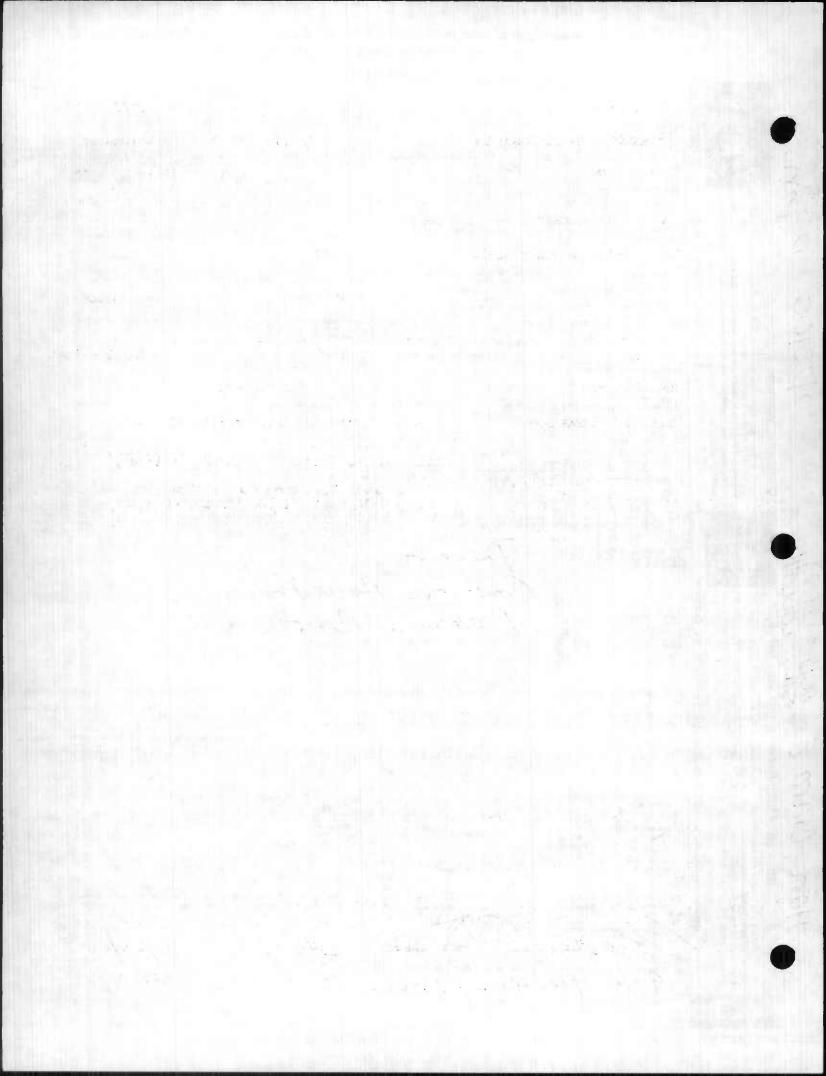
Registrar

18

30. Name and address of person who completed cause of deeth (field 23e) (Type, Print)

97/4 Healthway Dive

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Year **Physician** HUMPHREYS WILLIAM AUBREY March 2000 /Medical 4a Fscility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 24 Hrs. | 8 WICOMICO If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Deys Hours 10℃M 20 F 220-16-9600 Director February 21, 1929 Maryland Usual Residence of Decedent 10a Stata 10c. City, Town or Location 10d Inside City Limits Maryland Wicomico Delmar 1 TYAS 2 NO Funeral Director 250-7 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Itsms 23a or 21875 USA 29347 West Line Rd. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 🖾 No If Yas, Give 1 Never Married 2 Married 1 ☐ Yas 2 X No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Preston Trucking 17. Father's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Meiden Sumama) Be George Robert Humphreys Mary Olivia Gordy 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Ralationship (Type, Pnint) Item 27 is Hazel Lee Humphreys/Wife 29347 West Line Rd., Delmar, MD 21875 20b. Place of Disposition (Neme of cemetary, crematory or other place) Data 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 3/8/00 Springhill Memory Gardens Hebron, MD 4 ☐ Donstion 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensae 22. Name and Address of Facility M01051 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Finai diseese or condition resulting in daath) Examiner Physician/Medicai Examiner Sequentially list conditions, if any, leeding to immadiata cause. Entar Undarlying Cause (Diseese or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) NIDDM Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings avsilable prior to 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 No 1 ☐ Yes 2 No certificate 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medicai Certification: To 1 Yas 2 No 1 npatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Affer 5 Pending invastigation 1 SNatural after death. 1 Yas 2 No 2 Accident 6 Could not be within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifiar

The law requires that the death certificate be execu P.O. Division of Vital Records. or Attending Physician: Hospital

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Pages 1 and 2 should be nent of Health and Mental

altimore,

Box 68760.

State Registrar

29b. Signatura and titla of certifiar

30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print) MAR 0 8 2000

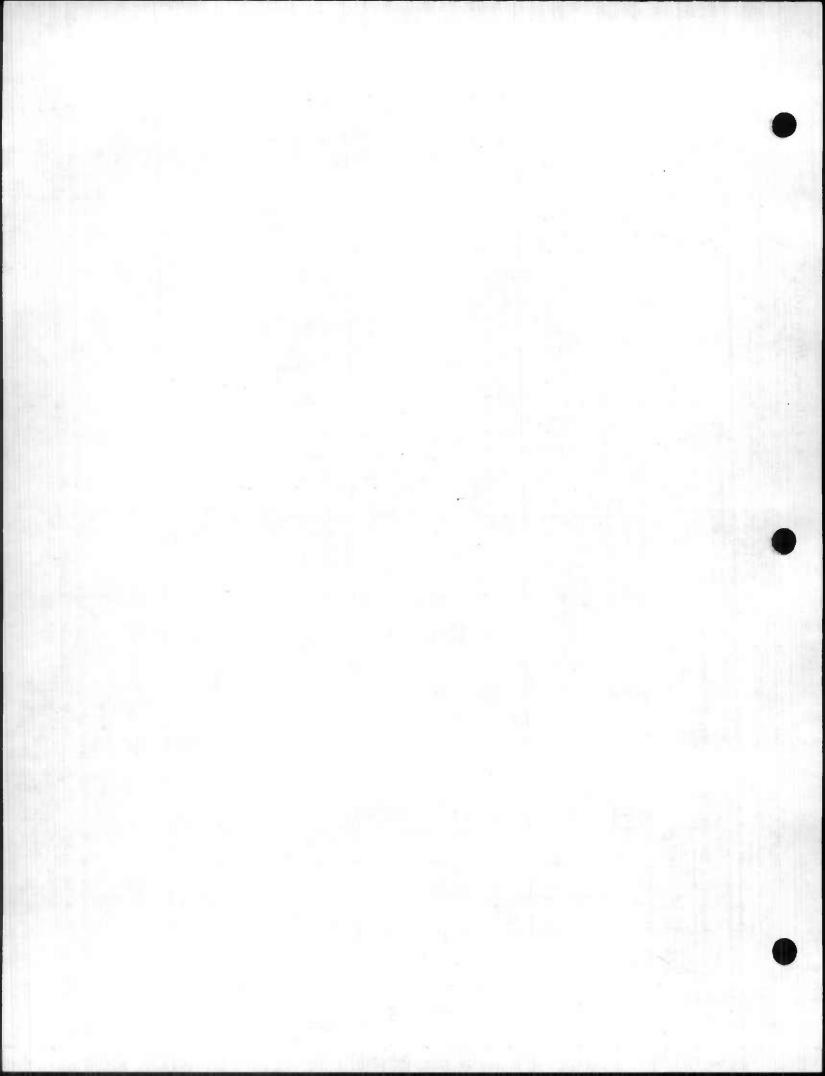
32. Registrar's Signature

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29c. Licanse number

29d. Data signed (Month, Day, Year)

DHMH 16 Rav 6/95



Piease Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** BESSIE HAMMOND A. 21, FEBRUARY 2000 4:15 A.M. /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING & REHABILITATION CENTER BERLIN WORCESTER If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F 217-01-8664 Director January 24,1913 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits must be notified at 10 Yes 2 No Director Maryland Wicomico Pittsville 10e Street and Number 10g, Citizen of What Country? 10f. Zip Code "natural", or items 23a or 5292 Powellville Rd. 21850 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: à White 3₺ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Seamstress Shirt Factory 8 cepartment of Health and Mental Hyga-important; if tem 27 is marked other to sny injury or other to 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Lest) Be Pages 1 and 2 should be L. Asbury Smith Charlotte Dennis 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Darlene H. Layfield/Daughter 6520 Sixty Foot Rd., Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Powellville Cemetery 2/24/00 Powellville, MD 4 Donation 5 Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Keith 501 Snow Hill Rd., Salisbury, MD 21804 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth /Medical Immediate Cause (Final ANDIAC HAREST disease or condition resulting in death) Examiner ANDAVASCULAR DISTAGE THERUSCLERYOTIC physician and the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ARDIOMYO PATTHY Physician/Medical Due to (or es a consequence of): attending Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? the the 3 1 Yaa 2 No 3 Probably 4 Unknown signed b by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en eutopsy Completed 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one)

Physician Examiner

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

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Division of Vital

Certification: To

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Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding Investigation 1 Netural
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 detailing Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) 29a. Certifier (Check only one) and manner stated.

10

Medical

29b. Signature end title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 410-641-0646 EDWIN CASTANEDA, M.D. 9714 HEALTHWAY DR., BERLIN, MD. 21811 31. Date filed (Month, Day, Year) FEB 2 3 2000

State Registrar

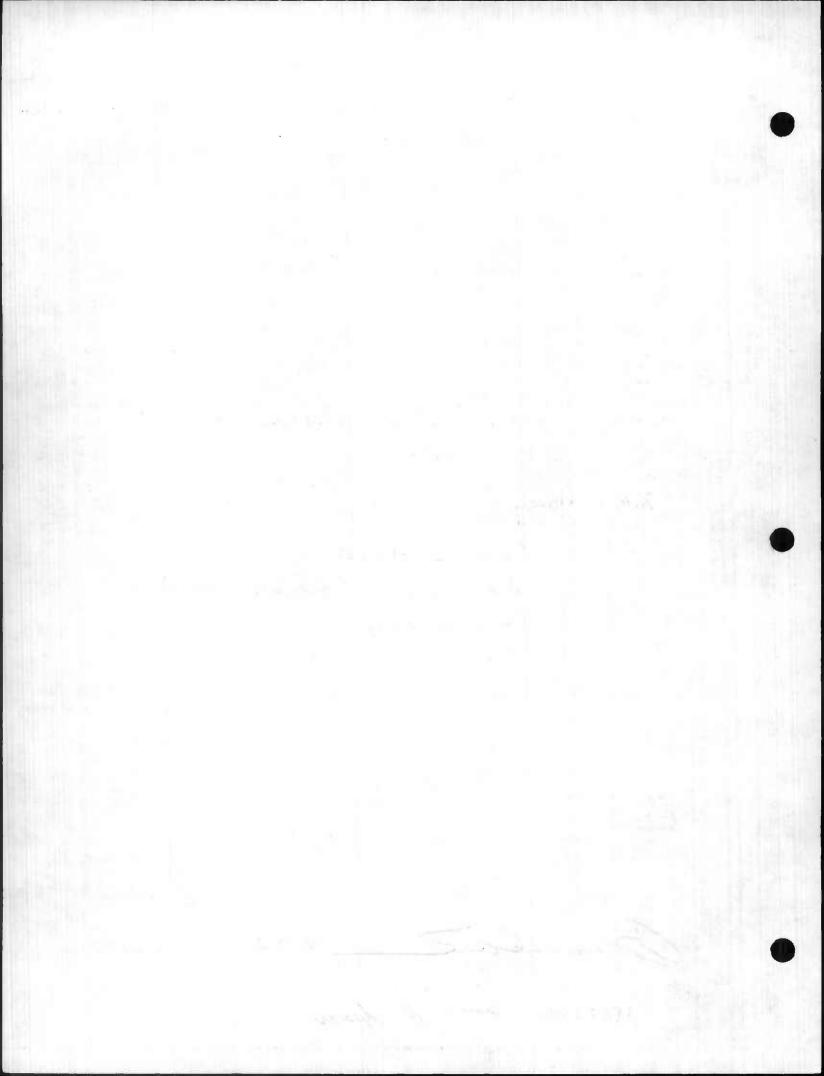
32. Registrar's Signeture

29c. License number

046257

29d. Date signed (Month, Day, Year)

To the Hosp within 24 ho To the Fune completely fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 6, March 2000 11:45pm Harper Edith 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Talbot William Hill Health Care If Undar 1 Yaer | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foraign 1□M 2XF Months Deys Hours Yrs. 88 Maryland 212-09-4692 May 10, 1911 Usual Rasidanca of Dacedani 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 □ No Talbot Easton Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21601 506 Bridge St. 12. Wes Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑No If Yas, Giva Year or Dates: Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Maritel Status 1 Naver Merried 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decadant's Education (Specify only highast grade complated) 16e. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working lifa. DO NOT usa retired) Elementery/Secondary (0-12) College (1-4or 5+) Yale Underwear Manager 18. Mothar's Name (First, Middle, Maidan Surname) 17. Fathar's Nema (First, Middla, Last) Mary Margaret Fairbank Edward Sears Harper Sr. 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informent's Name/Ralationship (Type, Print) 506 Bridge St. Easton, Maryland 21601 Beverly Hahn Niece 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Ramoval from Stata Capitol Crematory March 7, 2000 Dover, Delaware 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Addrass of Facility Harrison E. Leonard Funeral Home 21. Signatura of Funaral Service Licansaa 312 S. Talbot ST. St. Michaels, Maryland 21663 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Sequentially list conditions, if eny, laading to immadieta causa. Enter Undarlying Causa (Disease or Injury that initiated evants rasulting in deeth) Last Dua to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown generalize 24b. Wara autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work?

Physician /Medical Examiner Examiner

Physician

/Medical

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itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours after death v. Depertment of Heelth end Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a and hijury or other traumatic event, the Medical Examiner manal ence.

altimore, Maryland 21215-0020

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(Check only one)

29b. Signatura and title of cartiff

31. Data filad (Month, Day, Year)

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3 ☐ Suicida

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5 Pending Investigation

6 Could not be detarmined

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Box 68760 certificate be Records, P.O. Division of Vital al or Attending P safer death. After 2 To the Hospital o within 24 hours af To the Funeral Di completaly

State

Registrar

2 Medical Examiner: On the besis of examinetion and/or invastigation, in my opinion, deeth occurred at tha tima, date and place, end due to the ceuse(s) and mannar statad. 29c. License number

29d. Data signed (Month, Day, Year)

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Dutchmans

ধ Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated.

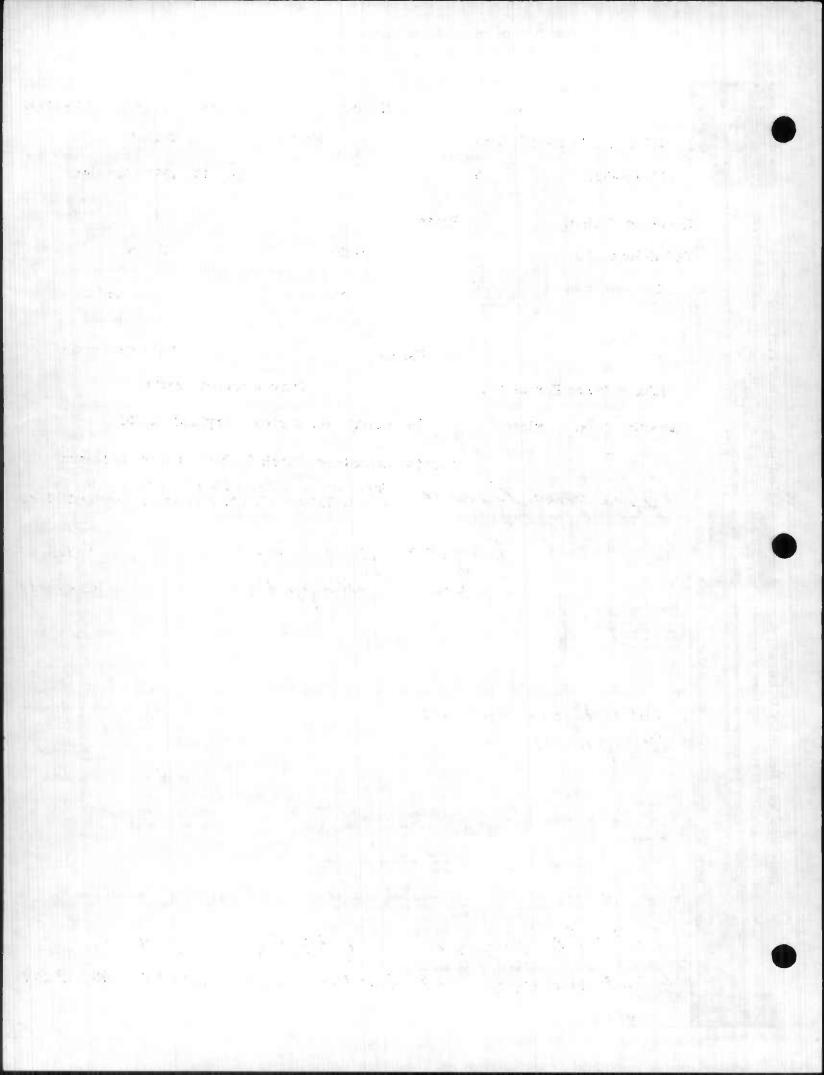
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28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)

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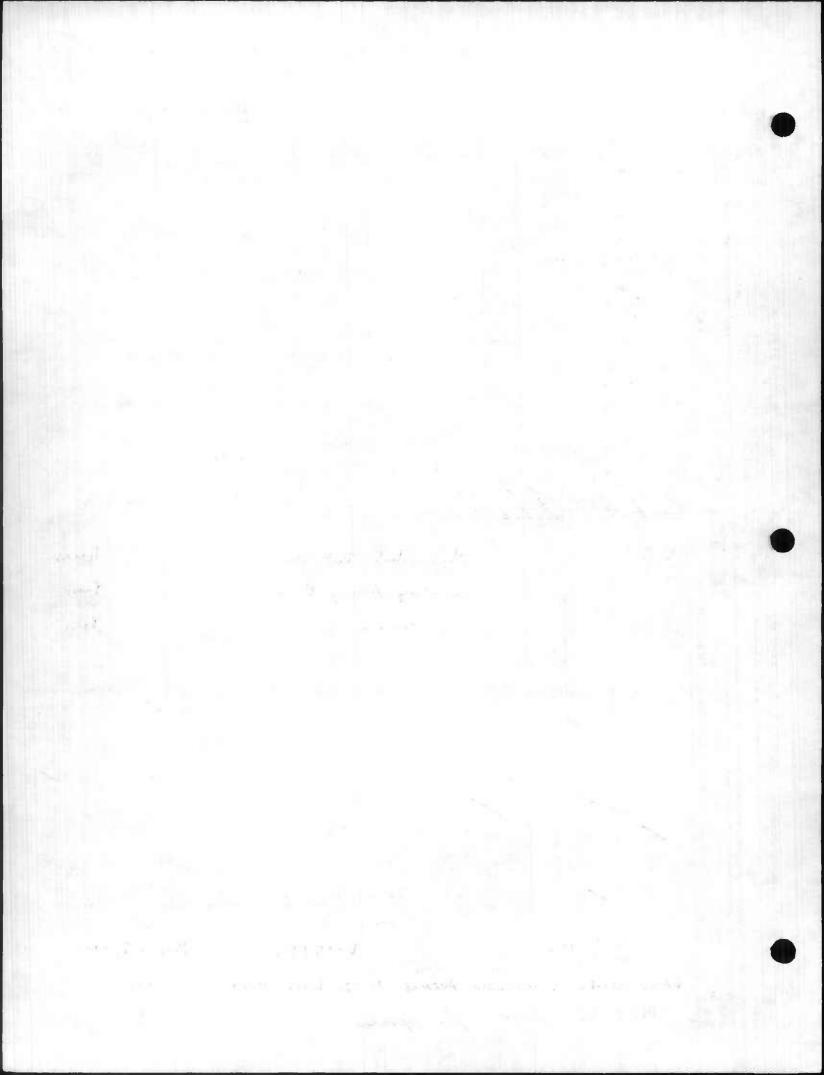
32 Registrar's Signatura

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	r tems 234	11. Meritel Stetus	12. Wes Decedent Ever in Armed Forces?	U,S. 13	If Yes, specify	of Hispanic Origin Cuban, Mexican, I	n? (Specify Yes or Neuerto Rican, etc.)	No- 14. Hace - Bleck, N	American Indian, White, etc.
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		231 Part / Enter the disease, or cell shook, or heart failure. List only	in the caused the decome cause on each line.	eth. Do not e	nter the mode of	dying, such as ca	ardiac or respiretory	arrest,	Approximete Intervet Between Onset end Deeth
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ō	6 6 5	27. Manney of Death	28a. Date of Injury	28b. Time		Injury at Work?		e how injury occurred	
5	th. After funer funer	1 ☑Naturel 5 ☐ Pending investigatio	(Month, Dey Year)	tnjury	М	Work? 1 ☐ Yes 2 ☐ No	0		
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á	tal or Attending P rs after death. al Director: After ted in by the funers Certification:	4 Homicide	building, etc. (Spec	iry)			City or I	own, Stete)	
	To the Hospital or Attendiguithin 24 bruns after death. To the Funeral Director: At completely filled in by the furnity Medical Certificati	29e. Certifler 1 Certifying Pt (Check only one)	nysician: To the best of my kr niner: On the basis of examin end menner steted.	owledge, dec ation and/or i	th occurred et the nvestigation, in a	e time, date end ny opinion, death	place, end due to the control occurred et the time	ne cause(s) end mann e, date and placa, and	er as steted. I due to the cause(s)
	withir To th comp	29b. Signeture and title of cartifier			29c. Li	cense number	i Webs	29d. Date signed (/	Month, Day, Year)
) and mo			Do	047711		March 7	, 2000
	10	30. Neme end address of person who	completed cause of death (Ite	m 23a) (Type					
	V	DAVID GAR-EL 3	MAULDIN A	surs	NONTH	EAST	MAGLIM	10716 01	
	State Registrar	MAR 0 8 2000	Server Sign	eture	a Val				



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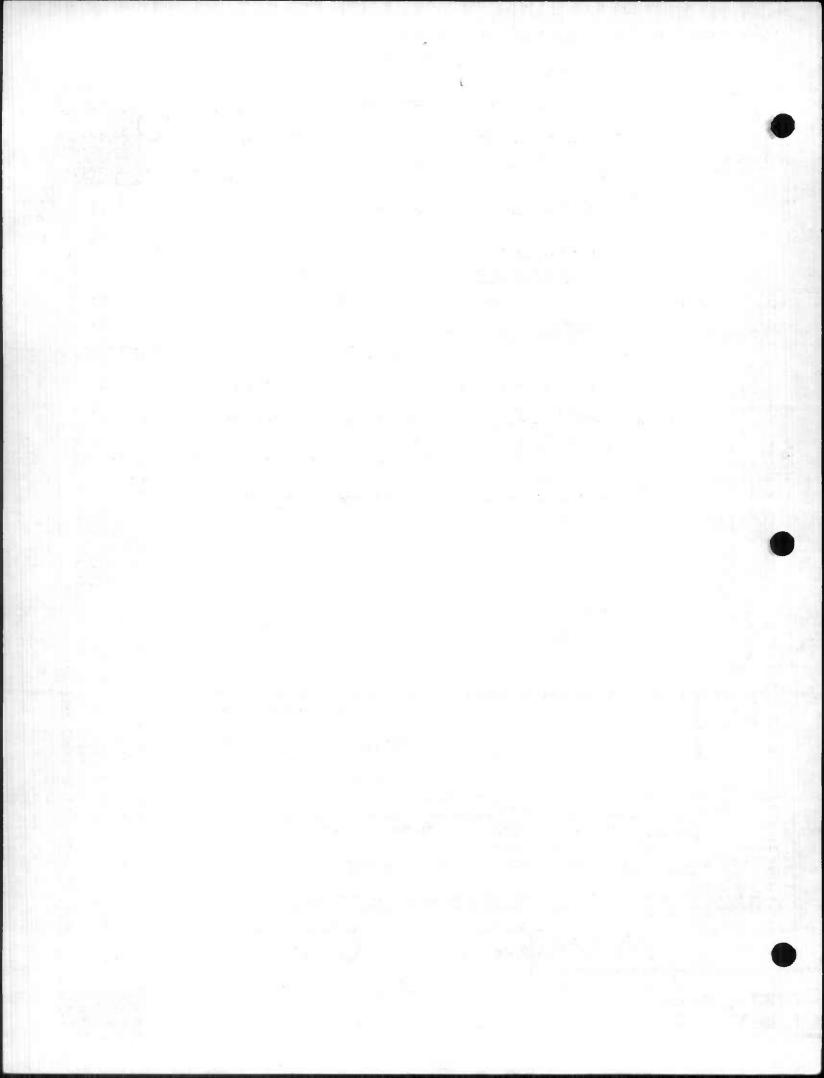
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Vaar **EVELYN** WINDSOR HOLLIDAY MARCH 11:57 Pm 8 2000 /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester General Hospital Dorchester If Under 1 Yeer | If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Aug. 31 Birthplaca (State or Foreign Country) **Funeral** Months 1□M 25F 85 1914 212-12-3208 Maryland Director Usual Rasidance of Decedant 10b. County Dorchester 10c. City, Town or Location Wingate 10d, Inside City Limits the Marylar r 28a-f show a notified at 1 Yas 27 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 119 an "natural", or items 23a or Medical Examiner must be r 21677 U.S.A. 2144 Wingate-Bishop Head Rd. Funerai permit. Pages 1 and 2 should be fied within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other treasments. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes ♣ No If Yes, Giva Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Nevar Married 2 ☐ Merried 1 ☐ Yas ZT No Specify: by Specify: White Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) Coilege (1-4or 5+) crab picker seafood 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be William. Hutson Windsor Annie 2 19a. Intormant's Neme/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3702 Devonshire Drive, Salisbury MD 21804 Lelia H. Robbins - daughter 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Dorchester Memorial Park 3-12-2000 Cambridge, Md. 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funaral Service Licensea 22. Nama and Addrass of Facility Thomas Funeral Home PA KennetteR Thomas 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. interval Between Onset and Death **Physician** /Medical Immediata Causa (Final Primonary Osauce disease or condition rasuiting in deeth) Examiner Dua to (or as a consequence of): Examiner Hypertensia physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underfying Causa (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): 89 080 been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 108 2 No 3 Probably 4 Unknown Division of Vital Records, þ Completed 24b. Wara autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? s certificate has b firector, page 2 s 1 Yas 2 No 1 ☐ Yas 20 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was casa ratarred to medical Be 28. Piece of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA 2 28a. Data of Injury (Month, Day Year) 27. Mannar of Death Certification: 28b. Time of 28c. injury et Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 Yas 2 No investigetion 2 Accident 6 Could not be datermined 3 Suicida 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At homa, tarm, street, tactory, office building, atc. (Specify) 4 Homicida edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end mannar as stated. 29e. Certifiar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titia of certified 29c. Licensa number 29d. Data signed (Month, Day, Year) U0053198 30. Nama end addrass of person who complated cause of deeth (Item 23a) (Type, Print) Mark & Velande, mo Cambridge MO 21613 503 BYRNST SUITE 1,

State Registrar 31. Dete tiled (Month, Day, Year) MAR 1 0 2000

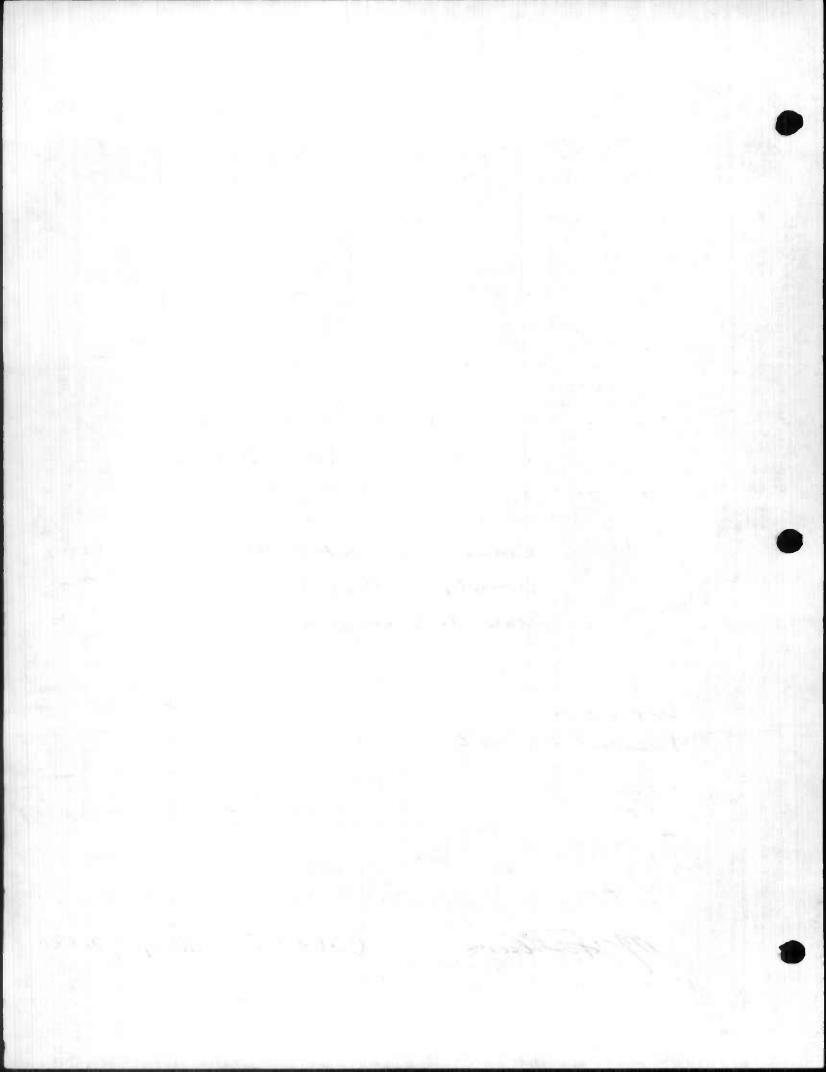
32. Registrar's Signatura

Deneva



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death Month MARIA HERWANDER 2104 06 2000 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death MONTEDNEW HOLY CROSS HOSPITTAL SILUBIL SONINZ If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-08-28 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign 1□ M 2X F Months Days Hours Min Yrs. El Salvador 592-60-6609 71 Usual Rasidenca of Decedant 10d. Insida City Limits 10a Stata 10b. County 10c. City, Town or Location 1 N Yes 2 □ No Silver Spring Md. Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3923 Wendy Lane 20910 El Salvador 12. Wes Decedent Evar In U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates: 1 Nevar Married 2 Married ¹X Yes 2□No Specify: El Salvadoran Specify: 3 Widowed 4 □ Divorced Hispanic 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5th Day-Care Provider Self-Employed 18. Mothar's Nama (First, Middle, Maldan Sumema) 17. Fether's Nama (First, Middla, Last) Virgilio Hernandez Ambrocia Lazo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) Fidel Barahona (Son-In-Law) 4177 Four Mile Run Dr. #103 Arlington, Va. 22204 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Family Cemetery MAR 1300 Morazan, El Salvador 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensae W. H. BACON FUNERAL HOME, INC. 20361 3447 14th St., N.W. Washington, D.C. 20010 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarvai Batween Onset and Daath Immediata Causa (Finel disaasa or condition rasulting in daath) ARTOUDSCURPETTY CHILDIDURSCULM DISTAST Due to (or as a consaquanca of) Sequentially list conditions, if any, leading to Immadiata causa. Entar Undarfying Causa (Disease or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 NO 1 ☐ Yas No 25. Wes case rafarred to medical examiner? 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 Yas 2 No Invastigation

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31. Data filed (Month, Day, Year)

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29e. Certifier

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1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and placa, end due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29d. Data signed (Month, Dey, Year) MARCH 07, 2000

28f. Location (Street and Number or Rural Route Number, Cify or Town, Steta)

30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Print).

CHALL MARGOLIS (NO. 11125 ROCKVILLE BIKE, PACKVILLE, NO. 2085)

MAR 0 9 2000

6 Could not be determined

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32. Ragistrar's Signetura

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

NEW STREET

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09665 Certificate of Death 2. Data of Death Month 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Day Year **Physician** 2000 Sannie 10:29AM Harley March 1, /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Hours 10 M 20 F Yrs. Aug. 1, 1923 Lodge, S.C. Director 577 22 3441 76 Usual Rasidanca of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show Yes 2 No Director 28a-f Washington, D.C. 10a Street and Number 10g. Citizen of What Country? 10f Zin Code 'natural', or hams 23s or 4849 Kansas Ave. N.W. 20011 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 ☐No If Yas, Giva 1X Nevar Married 2 Married 21215-0020 1 ☐ Yas 2 ☐XNo Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital 10th Grade L.P.N. Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) permit. Pages 1 and 2 should be fin Department of Health and Mental Hy Important: If Nem 27 is manked othe any Injury or other treumedic event 88 Vivian Hazel Ralph Harley 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Connie H. Walker/ Sister Same as: 10e,c,f. 20b. Place of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval trom Stata 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/7/2000 Alex. Va. 21. Signature of Funaral Sarvica Licansaa #CCO273 22. Nama and Addrass of Facility John T. Rhines Company As Wash., D.C. 20017 3030 12th St., N.E. 23a. Pg/1. Entar tha disaase, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory errest, spock, or haert tailure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediata Causa (Final 2010 auto all disaasa or condition resulting in death) Examiner Dua to (or es a consequence of): Examiner 7125 MOSTY Luco novo Sequentially list conditions, if any, leading to immadiate causa. Enter Undarlying Cause (Diseese or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760 DIONSERES MELCITUS Physician/Medical Dua to (or es a consequence of): Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? P.O. the signed by 1 Yes 2 No 3 Probably #⊞Wnknown BRAIN STUDIORS Records, by 24b. Ware autopsy findings svaitable prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 2 No 1 Yas 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical 29e. Certifier (Check only one) 29b. Signatura and titla of certitiar 29d. Data signed (Month, Day, Year) 29c. License number D25422 MARCH CAM 13952 BATIMONE AVE

State Registrar

MAR 0 7 2000

31. Data filad (Month, Day, Year)

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MACCIN, MD
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30. Nama and address of person who comptated causa of death (Item 23a) (Type, Print)

CAUREL, MD 20707

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Daath Day Month **Physician** Husted James Henry 7, 2000 1:40 a.m. March /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital | Winder 24 Hrs. | 6. Data of Birth (Month, Day, Year) | 9. Birthplaca (State or Foreign November 17, 1912 | New York 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Days Months 100 M 2□ F 003-03-9051 Director Usual Residence of Decedent 10a State 10b. County the Maryland 10c City Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Silver Spring 28a-f Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? finer must be n 20906-3920 United States Funeral 3403 May Street 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 8 White 1 Yes 2 No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Park Planner 12 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumeme) Pages 1 and 2 should be fit ment of Health and Mental H term 27 is marked oth luny or other traumatic even 80 Rostiser Jeremiah Anna Barbara Husted Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4288 Candlestick Court, Montclair, Va. 22026 Ann Husted Taylor / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If any injury or Parkview Cemetery 3/9/00 Schenectady, NY 21. Signature of Funaral Service Licenses 22. Name and Address of Facility
Rapp, Funeral and Cremation Services,
Stephen D. Lohrmann P. A.
933 Gist Ave., Silver Spring, Md. 20910 Lama C. Hardesly 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final 1 Day diseasa or condition resulting in death) Intracerebral Hemorrhage Examiner Due to (or as a consequence of) Examiner the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): US0 85 signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 WUnknown Division of Vitai Records. by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? peed page 2 1 Yas 2 No certificate 1 Yas 2 No or Attending Physician: funeral director. 25. Was casa refarred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1□ Yes 2個 No Medical Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Neturel 2 Accident e Hospital or Attending n 24 hours after death. ne Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Accertifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) end manner es stated.
2 The dical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and titla of certified 29c. License number 29d. Data signed (Month, Day, Year) mo ceuse of death (Item 23a) (Type, Print) Park Dr Silver Spring 20902 MD Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) March 8:45 AM **Physician** 2000 01, GLORIA S. IZLAR /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street and number) Examiner Prince Georges

9. Birthplace (State or Foreign Magnolia Nursing Home Lanham
If Under 24 Hrs 8. Date of Birth July 13, 1949

9. Birthplace (State or Foreign Country)
Washington, DC If Under 1 Year 7. Age (In yrs. lest birthday) 5. Sociel Security Number **Funeral** Days Min 1□ M 2♥ F Months Hours 50Yrs. 579-66-3870 Usuel Residence of Deceden Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Madical Examiner must be notlled at 1√1 Yes 2 □ No Maryland Prince Georges Directo Bladensburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5200 Newton Street, #T-1 Funeral 20710 U.S.A. 14. Race - American Indian, 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Yeer or Dates: Specify: Black 1 Yes 2 TNo Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 h and Mental Hygiena. College (1-4or 5+) Elamantary/Secondary (0-12) Operator Bell Atlantic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Walter Izlar Minerva Bynum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Haelth and Important: If itam 27 is m any Injury or other traum pncs. Daisy Braxton - Sister 3801 Kenilworth Ave. #213-W, Bladensburg, MD 20710

Be of Disposition (Name of Data 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20a. Method of Disposition 1 Buriel 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 3-9-00 4 ☐ Donation 5 ☐ Othar (Specify) Bladensburg, MD 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 21. Signature of Funerel Service Licenses 4217 9th Street N.W. Washington DC 20011 Mars ulia 23a. Part). Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition rasulting in death) a Chronic renal failure Examiner Due to (or as a consequenca of): Examiner Systemic Lupus Erythemetosis attending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): Congestive heart failure Physician/Medical Due to (or as a consequence of): as pericarditis Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. 23b. Did tobacco use contribute to the ceuse of death? ed by the a signed by t 1 Yes 2√2 No 3 Probably 4 Unknown Anemia, Hypertension by 24b. Were eutopsy findings available prior to completion of cause of daath? should I 24a. Was an autopsy Completed page 2 certificate has 1 Tes 2 No 1 □ Yes 2 □ No Be 25. Was cese referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No To this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how Injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Panding ours after deal.

V Director: Ah.
in by the fur-1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, afc. (Spacify) 4 Homlcida To the Hospital within 24 hours a To the Funeral C 29a. Cartifier 1 Cartifying Physician; To the best of my knowledga, death occurred at the tima, data and place, and dua to the causa(s) and manner as stated. edicai completely 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D14905 6 00

with the Maryland

death

72 hours after

requires that the death certificate be executed

aw

The

Physician:

Attending

Box 68760.

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Division of Vital Records,

Baltimore, Maryland 21215-0020

State Registrar Clear (WM H.

MAR 0 9 2000

31. Data filad (Month, Day, Year)

7307 Baltimore Ave. #111 Year-Kwon H. Yoon 32. Registrar's Signature

30. Name and address of person who completed ceusa of daath (Item 23a) (Type, Print)

College Park, MD 20740

DHMH 16 Rev 6/95

Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09669 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Day **Physician** 2 2000 4:10PM March Mack Jordan /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Silver Spring Springbrook Adventist Nursing Home Montgomery If Under 24 Hrs. 8. Date of Birth Hours Min. July 27, 1920 If Under 1 Yeer 9. Birthplaca (Stete or Foreign Country) Kansas 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Months 1₩ 2□ F 79 Yrs 492-14-7666 Director Usuel Residence of Decedent 10a. Slete 10d. Inaide City Limita 10b. County 10c. City, Town or Location 1 Nes 2 □ No Directo Washington 28a-f District of Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò munit be 20020 United States 2001 - 38th St., S.E. flering 23a Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 □XYes 2 □ No
If Yes, Give
Yeer or Deles: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Meritel Stelus Bleck, White, etc. African 1X Never Married 2 Merried Baltimore, Maryland 21215-0020 à 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced American natural Hygiene. other then "neturn ent, the Medical I Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grede completed) Elemantary/Secondary (0-12) College (1-4or 5+) Internal Revenue Service Government 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If Item 27 is marked of any Injury or other trainmetic eve John Jordan Emma Katon 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 2979 Maple Walk Ct., Lawrenceville, GA Michelle Kuykendall - Niece 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Melhod of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stele 3/8/2000 Brentwood, MD 4 ☐ Donelion 5 ☐ Other (Specify) Ft. Lincoln Cemetery 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 23a. Pert l. Enter the disease, or complications that batised the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** tmmediate Cause (Final diseesa or condition resulting in deeth) /Medical 2 Mos. Renal Failure Examiner Dua to (or as a consequence of): Examiner Cardiovascular Disease sician and burief-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaese or injury that initialed events resulting in death) Last Due to (or as a consequenca of). physician a Box 68760. Physician/Medicai Due to (or as a consequence of): 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 3 Probably 4 Unknown 2 1 Yes 2 No Lung Mass & Suspected Lung Cancer, Chronic Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed Obstructive Lung Disease, Hypertension, Anemia, page 2 s Dementia 1 Yes 2 No ...or Vital
...or pital or Attending Physician: Th
in 24 hours after death.
Ne Funeral Director: After this committee of the this committee of the think of the t 1 Yea 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2√ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dele of Injury (Month, Dey Year) 28b. Time of 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be delermined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - Al home, ferm, alreel, fectory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner ateted. 29e. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and 556 of offitties 29c. License number 29d. Date signed (Month, Day, Year) 3/6/00 D31001 30. Name and address of person who completed cause of deeth (Ilem 23a) (Type, Print) Turkewitz, M.D.; 7500 Greenway Ctr. Dr., #430; Greenbelt, MD Stuart J.

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Dey, Year)
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State of Maryland / Department of Health and Mental Hygiene 00 09670

				Cel	tificate o	Deat	n		Reg. No.			
Physician /Medical	1. Decedent's Nama (First, Middle Elizabeth Lou							2. Data of De Month March	3 200	Year 00	3. Time of Death 1:00 P.M.	
Examiner	4a Facility Name (If not institution Sunrise Indepen		sisted L					ark	4c. County of Death Anne Arun			
Funeral Director	5. Social Security Number 217 20 1530	6. Sex 1 ☐ M №2 F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Ye Months Day			8. Date of Bird (Month, Da Sept. 2	y, Year) 7, 1928	9. Birthe Cour Mary	placa (State or Foreign http) Land	
death with the Meryland ms 23s or 28s4 show Linut be notified at	10e. State 10b. County Maryland Anne		Crofton					10d. Inside City Lim 1 ☐ Yas ♣☐				
or 28	10e. Street and Number				10f. Zip Code	9			10g. Citizen of What Country?			
ath w	1564 Crofton P			114			United States					
urs effer Mr, or he by Fur	11. Marital Status 1 Never Married 2 Marr 文章 Widowed 4 Divorced	edent Ever in U,S. prces? Z No ve lates:	J.S. 13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric					Specify	k, Whita,			
72 hounnetural,	15. Decedent	's Education		16a. Deced	lent's Usual Oc	cupation	ant of word	ina	16b. Kind of Bu	usiness/In	dustry	
han han	(Specify only highest Elementary/Secondary (0-12) 12	College (1	1-4or 5+)	(Giva kind of work done during most of working lifa. DO NOT use retired) Homemaker					Own Home			
a sega	Clarence Webb Helen Marbel											
27 16 27 16 Tr.	John Juba, Jr.	hip (Type, Print)	Son	1620	Dryden	Way			er, City or Town, Land 211	14		
nit. Pages 1 en artment of Heali ortant: If Item 2: Injury or other 8.	20a. Method of Disposition t□Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	Stata	etary, cren	sition (Name of netory or other) n Natio	place)	March emete		2000. Location - City or Town, Stata Arlington Virgini				
Departm Departm Importar eny injur	21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Robert E. Evans Funera 16000 Annapolis Rd. Bo								l Home, Inc.			
deeth certificate be assected Wedical Examiner of for use as the buriel-transit sician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>50</u> b. <u>50</u> c	Due to (or a	s a consequence of a co	uence of): Lubi 74 uence of):	LS ,	wou	end			Infarval Batween Onset and Death 2d 3 week	
thet the dead by the detached	Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Advanced dements a										o the cause of death?	
aw requir				11		1		24a. Was perfo	an autopsy med?	av	are autopsy findings railable prior to impletion of cause death?	
Page P								10	Yes 2000	10	□ Yas 212 No	
Attending Physicians or death. ector: After this certific by the funeral director. Iffication: To Be	2 Accident investig	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho							dence 6 20th how injury occur	red	Assited Wiring	
To the Hospital or within 24 hours after To the Funeral Dir completally filled in Medical Cert		g Physician: To the Examiner: On the be										
To the compile	29b. Signature and title of cardiag	Zi	_ m	0	D-	50	725		29d. Date signe	d (Month,	Day, Year)	
10)	denniferRie	who completed caus	-MD	479	Jum,	pers	Hole	_ Seve	rna P.	ark	MD 2114	
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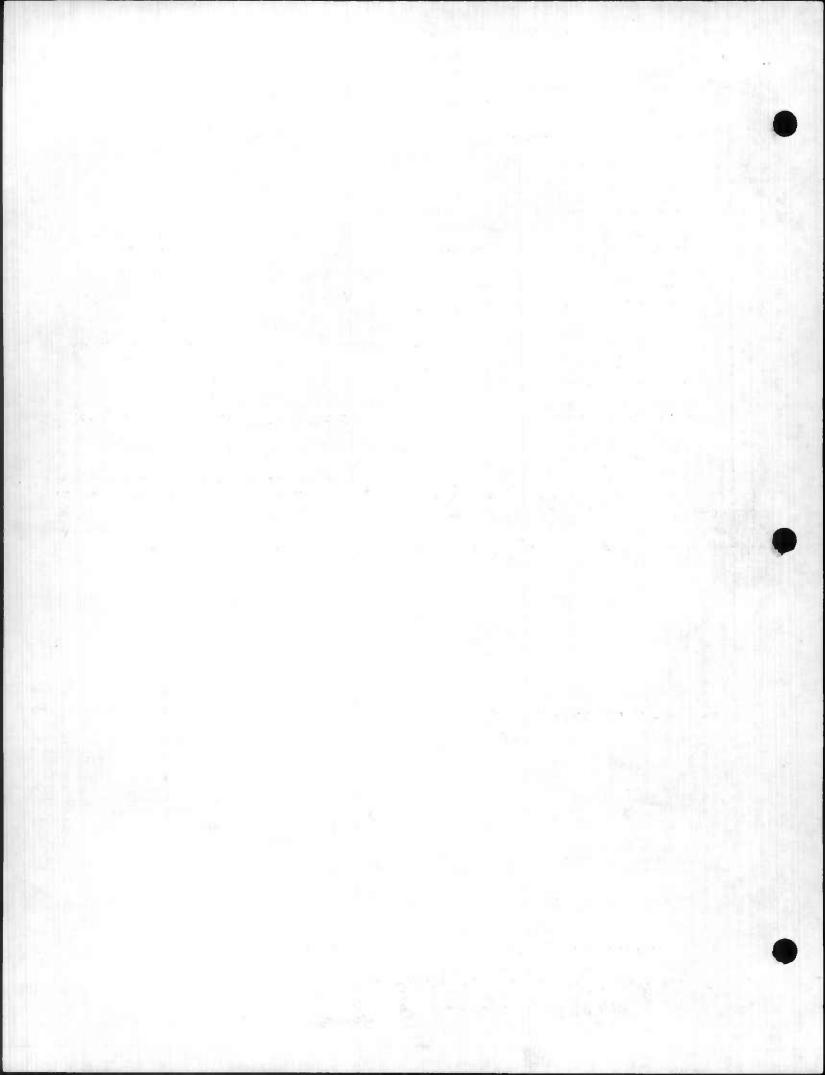
Marie Comment

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended #9/03-02-2000/WCHD/ HLC 1. Decedant's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 0642 ROY RAY **JEWELL** march - 1 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV 3, 1943 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) **Funeral** Days X M 2 F 56 221-52-9481 Yrs. NOV . Director AMERICA Usual Residence of Decedent DELAWARE 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits SEAFORD 1 ☐ Yes 2 No DELAWARE SUSSEX Director 288-7 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 23a or 1020 BRICKYARD RD LOT B 60 **AMERICA** 19973 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? ☐ Yes 21 No Yes, Give 1 Never Merried 2 ☐ Merried Specify: WHITE 21215-0020 ò 1 ☐ Yas 2 ☑ No Specify: À 3 Widowed 4 Divorced Yaer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) ASSEMBLER MANUFACTURING 4YRS. Maryland 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maiden Surname) Be RAY WILLIAM **JEWELL JENNY** COXE 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAYNE L. JEWELL 1020 BRICKYARD RD. LOTB 60 SEAFORD, DE. 19973 Item 27 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata 20a. Method of Disposition EASTERN SHORE 1 ☐ Buriel 2X Cremetion 3 ☐ Removal from Stete 3/2/2000 LEWES, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) CREMATORIUM
2. Name and Address of Fecility WATSON-YATES FUNERAL HOME, INC 21. Signature of Funeral Service Licensee FRONT & KING STREETS SEAFORD, DELAWARE Approximate 3 Intervel Between Onset end Death Pert 1. Enter the r complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, only one cause in each line. **Physician** /Medical Immediete Cause RESP. FAILURE 2489. disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be execu Box 68760, Physician/Medical the Dua to (or as a consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Récords, P.O. 1 ☐ Yes 2 ₹ No 3 Probably 4 Unknown VENTRICULAR SEPTAL DEFECT Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 Tes 2 No certificate 25. Wes case referred to medicat axaminer? director, 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 | Inpatient 2 | ER/Outpatient 30 DOA Certification: To 1 Yes 2 No this luneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Affer 5 Pending invastigation Division To the Hospital or Atlanding within 24 hours after death.

To the Funeral Director: After a contract of the funeral principles of the funeral princi 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifia: (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) main's would are D32014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 WILPORD ST SOUB SALISBYN MD 21804 MAMBY MOONDRA 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death JOHNSON Month 243 JAMES March JEON 3000 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Yeer Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 108M 20 F 219-03-5893 Yrs. Usuel Rasidence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No DOMERSET 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 8226 21867 USF 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Datas: 14. Rece - Amarican Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Never Merried 2 Married 1 Yas 2 No Specify BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) LINE-WORKER 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Sumema) JOHNSON B 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) IFE 8216-UPPERHIU Rd. 20b. Place of Disposition (Nama of comatary, cramatory or other place) MAKEARET M. JOHNSON-WIFE UPPER HILL MD. 20c. Location - City or Town, Stata 20e. Mathod of Disposition Data 1 Buriel 2 □ Cremation 3 □ Removel from Sfafe JOHNSON CEMETARY 3 11 00 UPPER HILL, 4 ☐ Donation 5 ☐ Othar (Specify) BENNIE SMITH F/H 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility 917-W. ISABELLA ST. SANSBURY, Md. 21801 23a. Part1. Enter the duestie, or complications that caused tha death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or hand failure. List only one ceuse on each line. Approximete Intarval Between Onset end Death immediata Causa (Final disaasa or condition resulting in death) Leukemia Dua to (or as a consequence of): Sequantially list conditions, if any, laeding to immediata cause. Enter Underlying Cause (Diseasa or injury that initieted events rasulting in death) Lasf Dua to (or es a consequence of): Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Unknown 24b. Were eutopsy findings available prior to complation of cause of death? 24a. Was an autopsy 2 XNo 1 Yas 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical examinar? 26. Place of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 1 Yas 2 No 5 Rasidence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 27 Mannar of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Netural 2 Accident 5 Pending invastigetion 1 Yas 2 No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated. 29a. Cartifiar

The law requires that the death certificate be execu Box 68760. the USB &S 1 P.0. Division of Vital Records, certificate hes or Attending Physician: this After within 24 hours after death. To the Funeral Director: Al filled in by To the Hospital

Physician

/Medical

Examiner

Director

Funeral

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Hygians. other than 'nature ent, the Medical I

Department of Health in Important: If Iham 27 is any Injury or other tra

Physician /Medical

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Certification: To Be

Medicai

(Check only one)

29b. Signatura and title of Certifier

1 and 2 should be Health and Mental

Pages hard of h

Baltimore,

Shrason

6 State

Registrar

DHMH 16 Rev 6/95

completely

livelde 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) Huddkston STION

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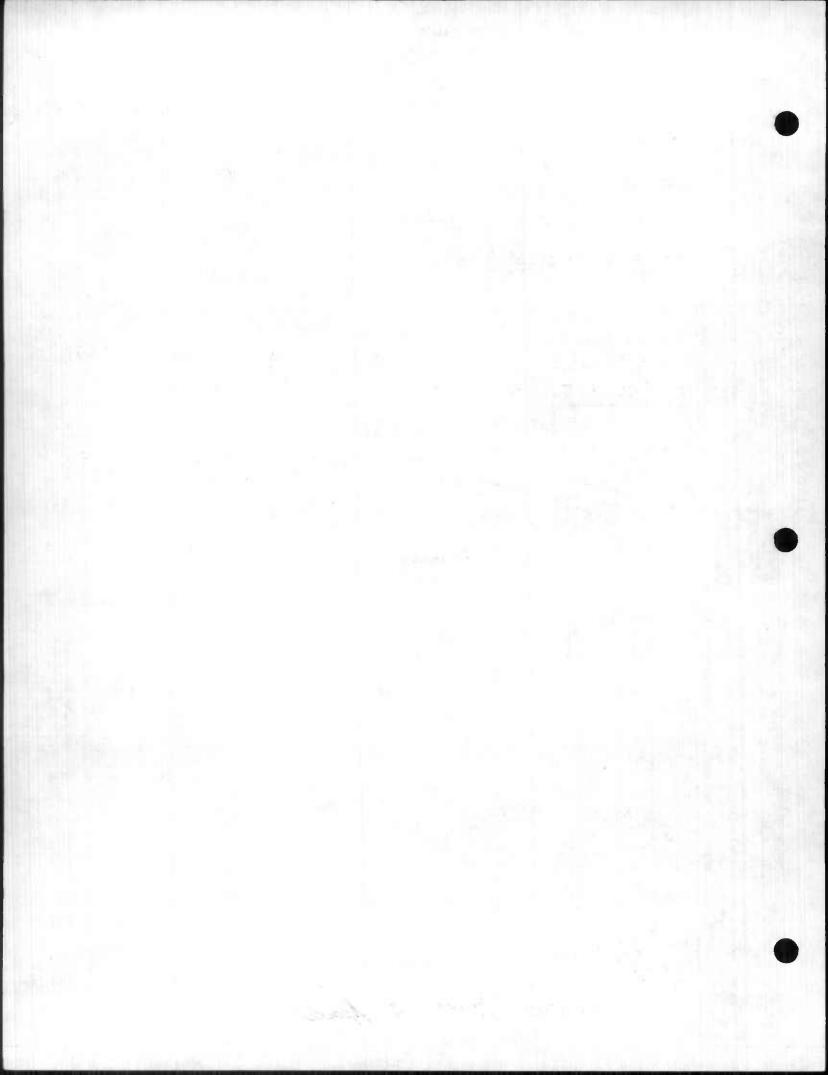
32. Registrar's Signature

Muford Street

29c. License number

29d. Data signed (Month, Day, Year) 00

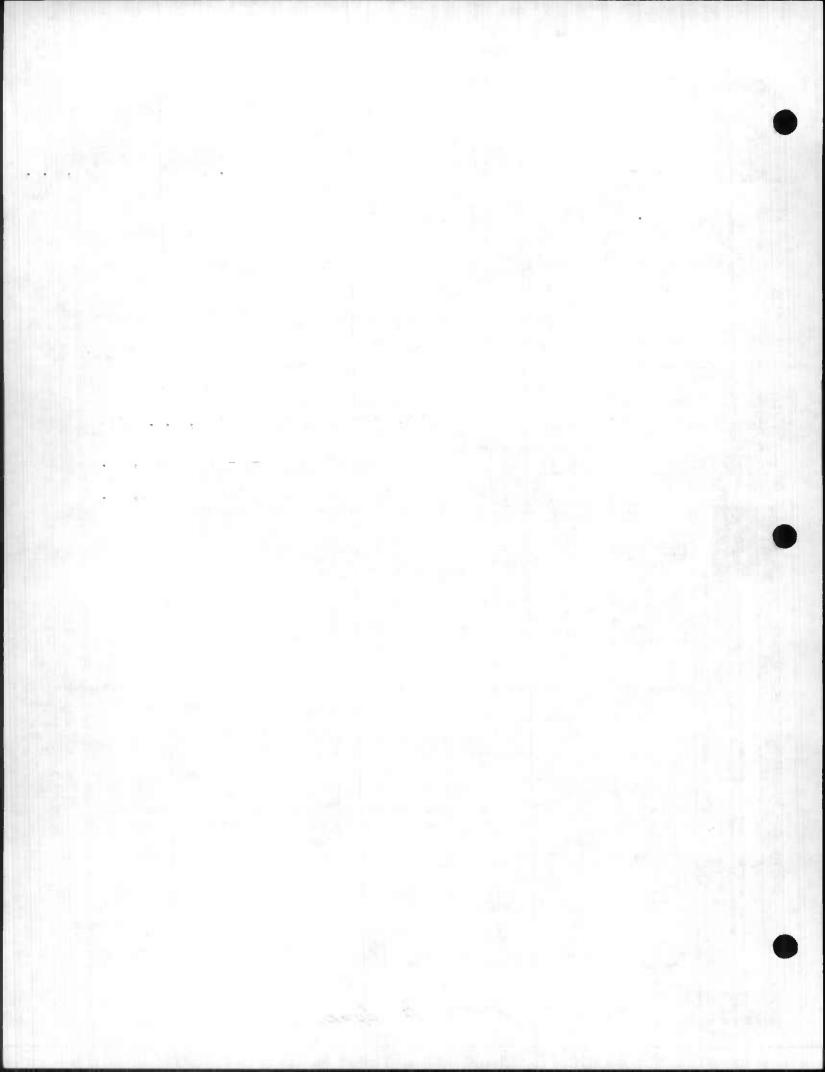
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		Decedent's Neme (First, Middle, Last)						of Death			3. Time of Death
Physician	LARRY	AARON JO	ONES					Month	Dey	2000	4:45 PM
/Medical Examiner	4s Facility Name	(If not institution, giv	re street and numbe	or)			4b. City, Town,	or Location of D		County of D	
	SALISBU	RY CENTER	GENESIS	ELDERO	CARE		SALISBU	JRY, MD	W	COMIC	CC
neral ector	5. Social Security 146-34-	6544	Sex 7. /	Age (In yrs. II 56	last birthday) Yrs.	If Under 1 Yea Months Day		Hrs. 8. Date of (Month) DEC.	Birth Dey, Year) 194	9. I 3 BE	Birthplace (State or Foreig Country) VERLEY, N.J.
be notified at Director	Usual Residence	of Decedent		10c. City	, Town or Loc	cation					10d. Inside City Limits
lo	MD.	WICOM:	ICO	MAR	RDFLA S	PRINGS					1 ☐ Yes 2 ☐ No
Directo	10e. Street and N					10f. Zip Code			10g. Citis	zen of What	Country?
		SAN DOMING	GO ROAD			2183	7			USA	
Funeral	11. Marital Status		12. Was Deceder Armed Forces		S. 13. W		Hispanic Origina ban, Mexican, Pa	(Specify Yes o	No-		merican Indien, /hite, etc.
þ	3 □ Widowed	arried 2 Merried 4 Divorced	1 [X] Yes 2 [If Yes, Give Year or Dates	No		□Yes 2 N					LACK
etec	(Sp	15. Decedent's Ed	ducation ade completed)		(Give k	ent's Usual Occ	e during most of	working	16b. Kir	nd of Busine	ess/Industry
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		e (First, Middle, Last)			Enbo	TICH.	18 Mother's	Name (First, Mid	Idle Maiden	Sumama)	
o Be		ROLAND					To: Miotalor 5				
10		Neme/Reletionship (_	19b. Meiting	g Address (Stre	et and Number o		RIE BE		e, Zip Code)
	ELAINE T				1617		STREET;		Description of the last		
	20a. Method of D				lace of Dispos	sition (Name of setory or other p		Date			or Town, Stata
		2 Cremetion 3 C		16		N CEMET		-13-00	HILDI	UCK I	MD
	21. Signature of	Funeral Service Licer	isee	MD	-	Name and Add		1213 JE	RSEY R	ROAD	NILZ.
	1	willa,	BUM	Pleas	/ J0	LLEY ME	MORIAL C				MD. 21801
- 6		1)		Due to (or	as a consequ		2 UN	Known	Pan	Arag	Emand
/Medical Examiner	Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated everesulting in death	conditions, immediate derlying or injury nts	b	Due to (or	r as a consequence as a consequence of a	uence of):	2 UN	Known	Prin	was	Emound
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by Physician/Medical	resulting in death	conditions, immediate derlying or injury nts 1) Last	b c d ontributing to death	Due to (or	es a consequ	uence of):		23b.	Did tobacco	usa contrib	outs to the cause of death
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edical Certification: To Be Completed by Physician/Medical	25. Was case refevaminer? 1 Yes 2 27. Manner of De 1 (DNatural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only	erred to medicat No ath 5 Pending investigation 6 Could not be determined	Hospital: 1 Inpe 28a. Date of in (Month, E) 28e. Place of fi building, (yelclan: To the basineer: On the basis	Due to (or Due to (or but not resultient 2 E sjury lay Year) Injury - At horetc. (Specify, st of my know of examinations)	es a conseque es	uence of): uence of): uence of): deriving cause graderlying gra	26. Place of hther: 4 Nursin ury at ork? Yes 2 No e time, date and ply opinion, death of	23b. 24a. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Old tobacco Vaa 2 Ves en autoperformed? Ves 2 Inly one) Residence (Ibe how Injury Town, State, the cause(s) The date end	No 3 No 3 No State of No	b. Were autopsy tindings aveilable prior to completion of cause of death? 1 Yes 2 No Specify) r Rural Route Number, r es stated. due to the cause(s)

Registra DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev **Physician** 0900 Isabella Fooks Johnson 2000 March /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 8. Dete of Birth (Month, Day, Year) Country)
Sant. 26 1930 Maryland If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 10 M 20 F Yrs. 220-26-3730 69 Sept.26 Director Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 TYBS 2 No 288-1 Directo Maryland Wicomico Parsonsburg must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Herne 23a U.S.A 32541 Old Ocean City Road 21849 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: should be filed within 72 hours after 1 Never Married 2 Married b Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black Aq 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic None 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) h and Mental ? Is marked of George Fooks Myrtle Palmer 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Pages 1 and 2 if item 27 i Luther Johnson (Husband) 32541 Old Ocean City Rd.Parsonsburg, Md.21849 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data 1 Burial 2 Cremetion 3 Removal from Stete ö Springhill Mem.Garden 4 ☐ Donation 5 ☐ Other (Specify) Hebron, Md. 22. Nama and Address of Facility
Stewart Funeral Home 21. Signeture of Funerel Service Licensee À 23a. Pert1. Enter the disease, or complications that callised the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or haert lailure. List only one cause on death line. 821 West Rd.Salisbury, Md.21801 Approximata Intervel Betw Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Lasl to (or as a consequence of): attending physician Physician/Medical the Dua to (or as a consequence of): US8 88 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed by 0 Completed by of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? been s this certificate has 1 ☐ Yes 2 ☐ No Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral funeral 28d. Describe how injury occurred 27. Mannes-of De 28b. Time of 28c. Injury at Work? 1 Neturel 2 Accident Division 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be datarmined 3 ☐ Suicide 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only 29b. Signal and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Ray 6/95

Eastern Shore Dr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

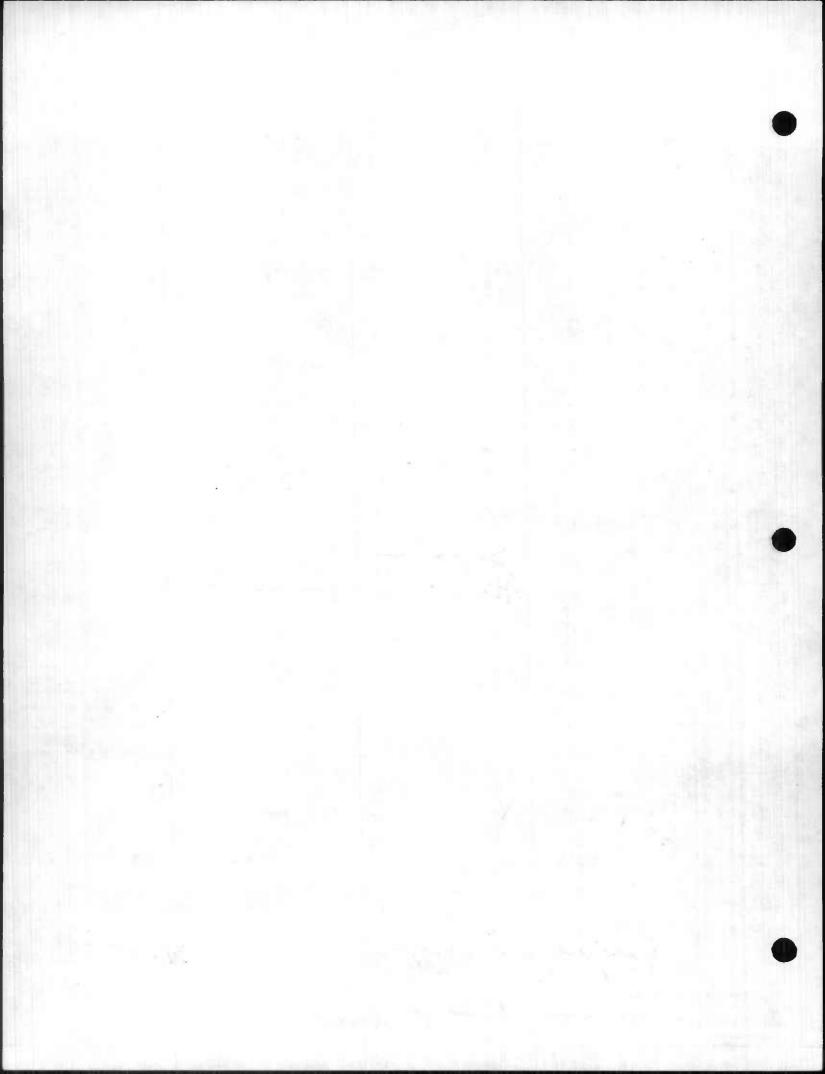
31. Data filed (Month, Day, Year)

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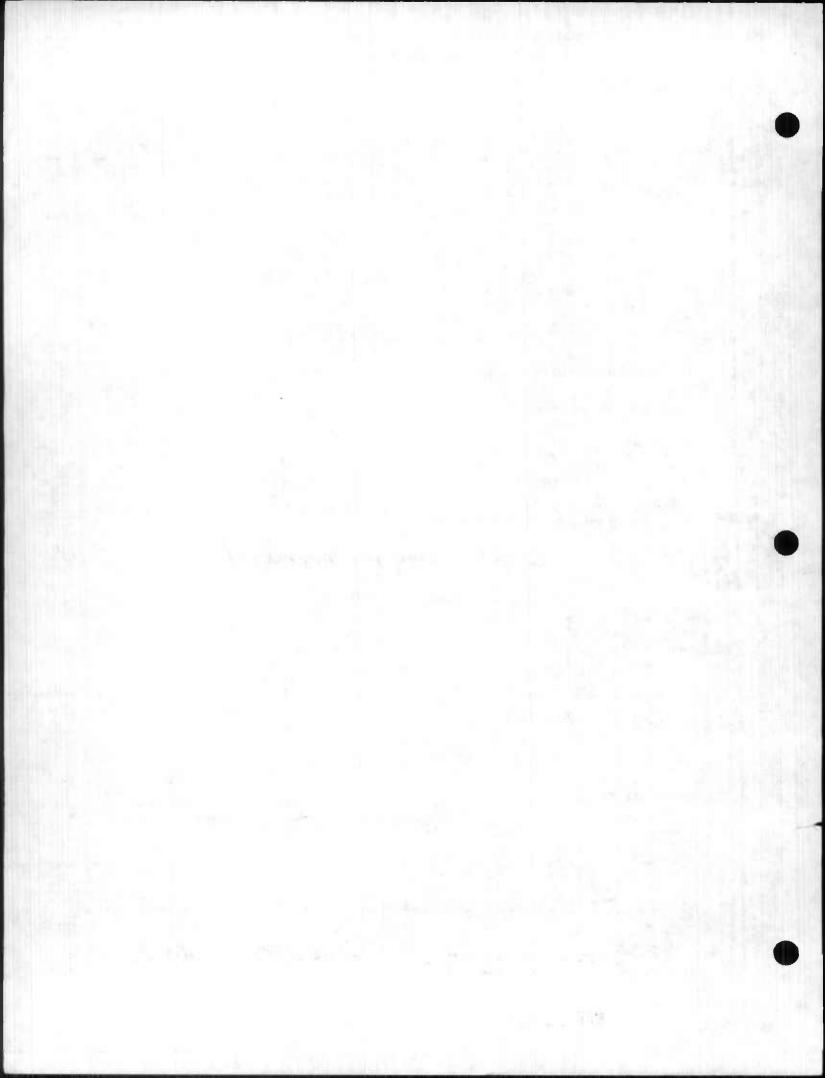
32. Begistrar's Signeture



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 9 6 7 5

			Ce	ertifica	te of	Death		R	eg. No.		
	1. Decedent's Neme (First, Middle, Last	1)				-, 1	2	. Date of Dear		Year	3. Time of Death
Physician /Medical	David	Jones					I	March	6 2	000	8:00AM
Examiner	4a Facility Name (If not institution, give Chesapeake Wo					4b. City, To Camb		tion of Death	4c. County Dorc		er
uneral irector	217-14-8256	7. Age (In yn	s. last birthdey Yrs.	Months	r 1 Yeer Days		24 Hrs. 8 Min.	Dete of Birth (Month Day April 2	¥,1908		eleca (Stete or Foreign etry) Land
show dat	Usual Residence of Decedent 10a. State 10b. County		City, Town or I	Location						10d. Inside City Limits 1 ☐ Yes 2 ₺ No	
pete other	Maryland Dorches	ster V	ienna								1 1 1 1 1 1 1 1
Herns 23e or 28e-f show ther must be notified at funeral Director	10e. Streef and Number 4871 Old Route	50		10f. Zip Code 21869					10g. Citizen of What Country? USA		
Example Dy F	11. Merifel Stefus 1 Never Married 2 Merried 3 X Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	U,S. 13		,	Hispanic Ori ean, Mexican Specify:	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)		k, White,	en Indien, etc. Lack
ical feat	15. Decedent's Edu	ucation	16a. Decedent's l			petion most	t of working		16b. Kind of Bu	siness/Inc	dustry
t, the Medical of	(Specify only highest gred Elementery/Secondery (0-12)	College (1-4or 5+)	(Give kind of wo. iile. DO NOT us			od)	t or working		Cannery		
9 9	17. Father's Name (First, Middle, Last)				0	_	r's Name (First, Middle, i	Maiden Sumem	9)	
marked commercial	Daniel II Io	200 62				Mon		Manak	0.37		
The Party	David W. Jos	nes, Sr.	19b. Mai	ilina Addres	s (Stree	Mar t end Number	9	Manok	r, City or Town,	State, Zip	Code)
# 2	Dorothy M. Jacks			_					yland 2		
other tr	20a. Method of Disposition		Place of Disp	position (Ne	me of			Date	20c. Location -		own, State
lant: If it	1 M Burial 2 □ Cremetion 3 □ F 4 □ Donation 5 □ Other (Specify,)	cemetery, co	rove	Ceme	etery		11/00	Reids G	rove	,Maryland
any in	21. Signature of Funeral Service Licens	MACO)		Benni	e St		unera	1 Home	and 216	01	
miner Examiner	resulting in death)	b	Und (or as a consi	equence of):	Jou	de	at			2 W/s
as the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underthying Cause (Disease or Injury thet Initiated events resulting in death) Last	С	(or as a conse								
d for us	Part II. Other significant conditions co	cause di	use given in Part f. 23b. Df			old tobacco use contribute to the cause of d					
detached for use	Domentin		Journal III (110	undonying	oauso gi	VOTINT UIT		1 D Y			bebly 4 Unknow
cate hes been signed in page 2 should be det Completed by P								24a. Was a perfor		CO	ere autopsy findings allable prior to impletion of cause death?
certificate hes rector, page 2 Be Comp								1 U Y	es 20 No	10	Yas 25 No.
ertifica sctor, p Be C	25. Wes case referred to medical					26. Place	of Death /	Check only or	10)		
I direct	examiner?	Hospital:	□ FR/Outpati	Othor			g Home 5 Residence 6 Other (Special Describe how injury occurred		er (Specif	(v)	
Director: After this I in by the funeral di ertification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Day Year)	28b. Time	8b. Time of tnjury M 28c. Injury at Work?		28				,,	
To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Af building, etc. (Spec	ce of Injury - Af home, ferm, street, fectory, office ding, efc. (Specify) 28f. Location (Street and Number or Rurel Route Numb City or Town, State)						al Route Number,		
Pletely fills	29e. Certifier (Check only one) Check only one)	elclan: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, dea nation and/or i	ath occurred investigation	at the to	ime, date an opinion, dea	d placa, an th occurred	d due to the o	ause(s) end ma late and place,	nner as a and due to	stated. the cause(s)
To the Funeral completely filled Medical C	29b. Signature and title of certifier			29	c. Licen	se number		1 2	9d. Date signe	d (Month,	Day, Year)
-0	my	200,00			A	262	90		Mm "	7)	000
	30. Name and address of person who co	ompleted cause of death (Ite	em 23a) (Type	e, Print)	00		00		10/11 /	10	21643
	31. Dete filed (Month, Dey, Year)	de Mb. 3 32. Registrar' Sig	02 6	201/1	15	Ave	, 1	tur lo	ct, N	nd s	21643
State	MAR 1 (2000 N Den	ave.	19.	de	rach	/				

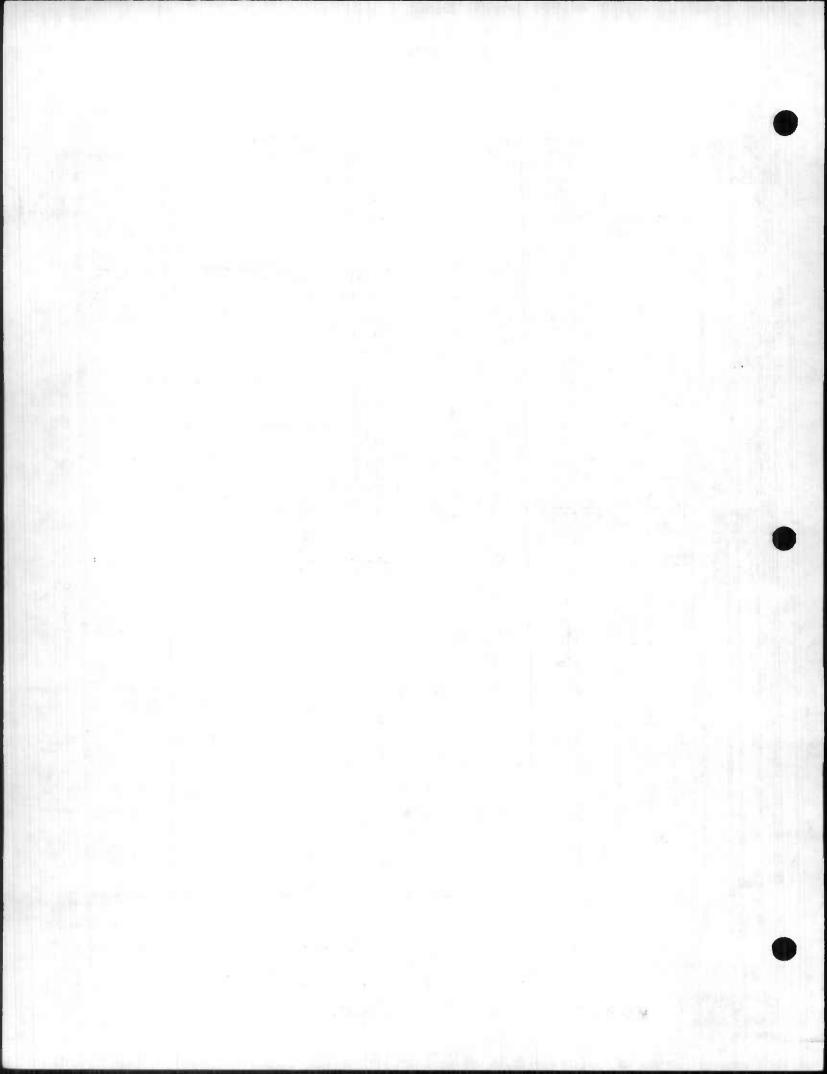


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			C	ertifica	te of	Death		Reg. No.	0 0:	1010	
Physician	Decedent'a Nama (First, Middla, La						2. Date of De Month	Dey	Year	Tima of Death	
/Medical	Thomas	Edward	Jer	nkins			MARCH	-1		1810	
Examiner	4a Facility Name (If not institution, giv						Location of Deat				
	Union H		- 1 - 4 1 1 at a	W Hod	er 1 Year	Elkt M Under 24 Hr			Cecil	<i>1</i> 0	
Funeral Director	202-18-7059	7. Age (In yr	s. last birtho Yrs	Months					Country)	(State or Foreig	
ene. than "natural", or flems 23e or 25e-f show he Madical Examiner must be notified at ompleted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	10d. le	nsida City Limits								
r hems 23s or 28s-f shooten must be notified. Funeral Director	Maryland Cecil		1 ☐ Yes								
Dire Dire	10e. Street and Number		10g. Citizen of What Country?								
m 23	461 Little Egypt						Specify Yes or No	United States ecify Yes or No- 14. Race - Amarican Indian.			
th and Mental Hyglene. 71s marked other than "natural", or items 23s or 28s-f show traumetic avent, the Medical Examinar must be notified at traumetic avent, the Medical Examinar must be notified at To Be Completed by Funeral Director	1 Never Married 21 Married 3 Widowed 4 Divorced	Armed Forces? 1 N Yes 2 No If Yes, Give Year or Datas: 194	13. Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puarto Rican, atc 1 ☐ Yas 2 ☒ No Specify:				Black, White, atc. Specify: White				
	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. De	ecedent's Us iva kind of w a. DO NOT	ual Occu ork done use retire	pation during most of w d)	orking 16b. Kind of Business/In			у	
E C	7		I	lumbe	r/Ow	ner		Plumb.	ing		
avent, tr	17. Father's Nama (First, Middla, Last,						ama (First, Middle				
arked out ave	John L. Jenki						Josephin				
la mu	19a. Informant's Name/Relationship (t and Number or F					
am 27 ther tr	Edith M. Jenkin 20a. Mathod of Disposition					gypt Roa	d, Elkto		land 219 - City or Town,		
mt: If its	1 X Burial 2 ☐ Cremation 3 ☐	removal from Stata		sposition (Na crematory or					- City or Town,	State	
them.	4 Donetion 5 Other (Specif	0.	lpin			rial Pk.	3/11/00	Elkto	n, Mary	land	
Important: If ham 27 any Injury or other tr pncs.	21. Signature of Funeral Service Licer	1500				ess of Fecility e for Fu	nerals.	P.A.			
	Donud &	yland 2									
	23a. Part1. Entar tha disaase, or com shock, or haart tailura. List only	Inte	proximate erval Batween set and Death								
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miner	disaese or condition rasulting in death)	· outo				un force	DOU				
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min min	Samuela lle liet and divine	b	(or se s cou	sequence of	١٠				10 ys		
prysician and s the burlal-transit edical Examir	if any, leading to immediata	^		Sequence of	,-				14	1. 1	
the buriel-transit	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):								- 1	- degs	
o strending pl d for use as t ician/Med					1						
ched ched	Part It. Other significant conditions of	iven in Part I.	V			causa of death					
dets V							. 198	Yaa 2□ No	3 Probably	y 4 Unknow	
page 2 should be detached for usa Completed by Physician/W									availab	autopsy findings ble prior to bation of cause	
page 2							10	Yes 20 No	1 □ Ye		
entific sctor,	25. Was case refarred to medicat examiner?					26. Place of D	eeth (Check only	one)			
To dire	1 Yes 2 No		☐ ER/Outpe	tient 3 C	MOA		Home 5 ☐ Res	dence 8 Ot	har (Specify)		
After the funeral funeral funeral tion:	27. Mannar of Death 1	28a. Date of tnjury (Month, Day Year) 28b. Tima of Injury Work?					28d. Describe how injury occurred				
To the Funeral Director: After this certificata ha completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of trijury - At home, farm, street, tactory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, Stata)			
mpletely fill.		ysician: To the best of my kininer: On the basis of axami and manner stated.									
Me Me	29b. Signeture and title of certifier			2	9c. Licen	se number		29d. Date sign	ed (Month, Day,	Year)	
1	> Juv ch	il Han HD		1	00	4823			12000		
+114	30. Name and address of person who	completed cause of death (It	om 23a) (Ty	pe, Print) West	- m	and st	. EHCHO	n 40	15 K	921	
State	31. Data tiled (Month, Day, Year)	32. Registrar's Sig	natura	1							

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Dey Month **Physician** MARCH 8, JEAN CAROLINE JENSEN 2000 3:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS-LOCH RAVEN NURSING CENTER BALTIMORE BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer 8. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 10M 20F Months Yrs. Director 215-28-5144 70 MAY 24, 1929 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director 28a-f MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? ò therms 23a or Funeral 8720 EMGE ROAD 21234 UNITED STATES 11 Merital Status 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Pages 1 and 2 should be flied within 72 hours after of near of Health and Mental Hygienu. nts if term 27 is merical other than "natural", or than any or other traumatic event, the Medical Examples. Bleck, Whita, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detas: 1 Never Married 2 Married 21215-0020 Specific WHITE 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY/CASHIER ELECTRICAL CORP. Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be JAMES RUSSELL PEELING NORMA GERALDINE YOUNG 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) JAMES R. PEELING, JR/brother 12326 Harford Rd, Hydes, MD 21082 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from Stata Kriders Lutheran Cemetery 3/10 4 ☐ Donetion 5 ☐ Other (Specify) Westminster, MD 21. Signeture of Funerel Service Licensee 22, Nama end Address of Facility Myers Funeral Home 91 Willis Street Migers full Westminster, MD 21157 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical the th Due to (or as a consequence of): 8 980 signed by the at d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown 0 Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate hes page 2 2 12 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physician: director. 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes/ 20 No Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 24 hours after deeth.

Funeral Director: A 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, ferm, street, lectory, office building, atc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to tha cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and little of certifier 00 use of death (Item 20a) (Type, Print) 30. Nama and address of person who completed a York Rd, Ste 24, Timonium, MD 21093 1205 Wiegmann M.D. Francis 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar MAR 1 0 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death March 1:16 AM 06, 2000 CURTIS JONES, SR. 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death DOCTOR'S COMMUNITY HOSPITAL T.ANHAM PRINCE GEORGE'S If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) September 1, 1935 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Days Hours 10XM 2□ F 246-48-4698 64 South Carolina Yrs Usual Rasidenca of Decedant 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYas 2 □ No Prince George's Seat Pleasant Maryland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 20743 722 Booker Drive II.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 ☐ Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) Collega (1-4or 5+) Electrician Government 12th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Willie Jones Gertrude McNair 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Clementine Jones/Wife 722 Booker Drive, Seat Pleasant, Maryland 20743 20b. Place of Disposition (Name of cematery, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition 03/10 1 XBurial 2 ☐ Cramation 3 ☐ Removal Irom Stata Maryland Nat'l Mem. Park 2000 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intarval Batween Onsat and Death Ssigateon Presenance Immediata Ceusa (Final disaasa or condition rasulting in death) 1 hule Due to (or as a consequence of): new EVA Dua to (or as a consequence of): Dua to (or es a consequence of): 23b. Did tobacco uss contributs to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy 20 No 1 ☐ Yes 2 1 No 1 ☐ Yas

Physician /Medical Examiner

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician:

Hospital

Department of Health a Important: If them 27 is any injury or other trax

Physician

/Medical

Examiner

Funeral

Director

must be notified at

Berra 23a

Director

Funeral

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Completed

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Examiner Physician/Medicai should be det þ Completed Be Certification: To this After death. 24 hours after deat Funeral Director: filled in by

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was casa refarred to medical 26. Placa of Death (Check only ona) Hospital: 1 Unpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yas 2 No Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 MNatural 1 Yas 2 No 2 Accidant 6 Could not be determined Location (Street and Number or Rural Routa Number, City or Town, Stala) 3 ☐ Suicide 28a. Placa ol Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifian (Check only one)

RAMIESH PATEL

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31. Data filed (Month, Day, Year) State MAR 0 7 2000 Registrar

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) from Eill-32 Registrar's Signatura

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and 2000 RAMESH PATEL, M.D.

29c. License number

29d. Data signed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death d'anth **Physician** 02 2000 ANNIE P. **JENKINS** 6:30 AM /Medical 4a Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH CARE OF SOUTHERN MD CLINTON PRINCE GEORGE'S If Under 24 Hrs 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 M 20 F 579-48-0344 81 November 20,1918 Washington, D.C. Director Usuel Rasidenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Maryla 1 N Yes 2 No Maryland Prince George's Temple Hills Directo 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code ð 20748 4123 Carozza Court U.S.A. Nerns 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②XNo if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritai Status Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 XNo Specify: Specify: Black. by 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grede completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Domestic Worker Private permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg.
Important: If Nem 27 is marked other any Injury or other traument of the same pages. 18. Mothar's Name (First, Middle, Maiden Sumeme) 17. Fether's Nema (First, Middle, Last) Be Henry Ross Cornelius Harris 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Ralationship (Type, Print) 4123 Carozza Court, Temple Hills, Maryland 20748 Joyce Davis/Daughter 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 03/08 1X Buriel 2 Cremetion 3 Removel from State Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 2000 J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee Percen 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel diseasa or condition resulting in deeth) END STAGE RENAL FAILURE Examiner Due to (or as e consequence of): Examiner HTN the death certificate be executed physician and is the burial-trans Sequentielly list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequance of): Box 68760. PVD Physician/Medicai Due to (or es e consequence of): SEPTICEMIA 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, þ The law requires 24b. Were autopsy findings available prior to completion of cause of death? ahould l 24e. Wes an autopsy performed? Completed page 2 a certificate has 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa referred to medical axeminar? Be 26. Placa of Deeth (Check only one) Hospitel: Other: 41 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28d Describe how injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: A 2 Accidant 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 24 hours after de Funeral Direct letely filled in by 4 ☐ Homicide Hospital 29a. Certifier 🛣 Certifying Physician: To tha best of my knowledga, death occurred at the time, data end place, and dua to the cause(s) and menner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. To the F within 2. To the F complet 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25640 03/03/2000 Sa MO -91 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 7801 Old Branch Ave., Suite 409, Clinton, MD 20735 K. Davachi, M.D.

State Registrar 31. Data filled (Month, Day, Year)

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Registrar's Signatura

Registrar's Signatura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Tadeusz Kmiecik 2000 10:45pm February 28, /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Futurecare - Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1₽M 2□ F Months 056-30-3650 79 Yrs. Director Sept 17, 1920 Poland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or hams 23s or 28s-f show Anne Arundel Arnold 1 Yes & No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 College Parkway USA 21012 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Black, Whita, etc. 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 2√ No Specify: White þ 3 Widowed 4 ☐ Divorced Completed Pages 1 and 2 should be filled within 72 hours of Health and Mental Hygiene.

In If Item 27 is marked other than "naturary or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Psychiatry Physician Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Kmiecik Anna Korbala 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Nutile/ daughter 104 Hollyberry Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Mar 3 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Forest Lawn Cemetery Buffalo, NY 4 Donation 5 Other (Spe 2000 Name and Address of Fecility P.A. Severna Park Funeral Home Signature of Funeral Service Lice 495 Gov. Ritchie Hwy., Severna Pasrk, not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Batween Onset end Deeth Physician Iweek Immediate Cause (Final disease of condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Exam Box 68760 Physician/Medical \$ Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, hq 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 200 No 1 Yes 2 No of Vital Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) To Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA # 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Certification: Alter 5 Pending investigation Division 1 Yes 2 No 2 Accident 24 hours after deal Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 8 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the f ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified MD 2/29/00 - 50725 Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 479 Sumpers Hole Rd Severna Park Mi

DHMH 16 Rav 6/95

State

Registrar

31. Date filed (Month, Day, Year)

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32. Pegistrar's Signature

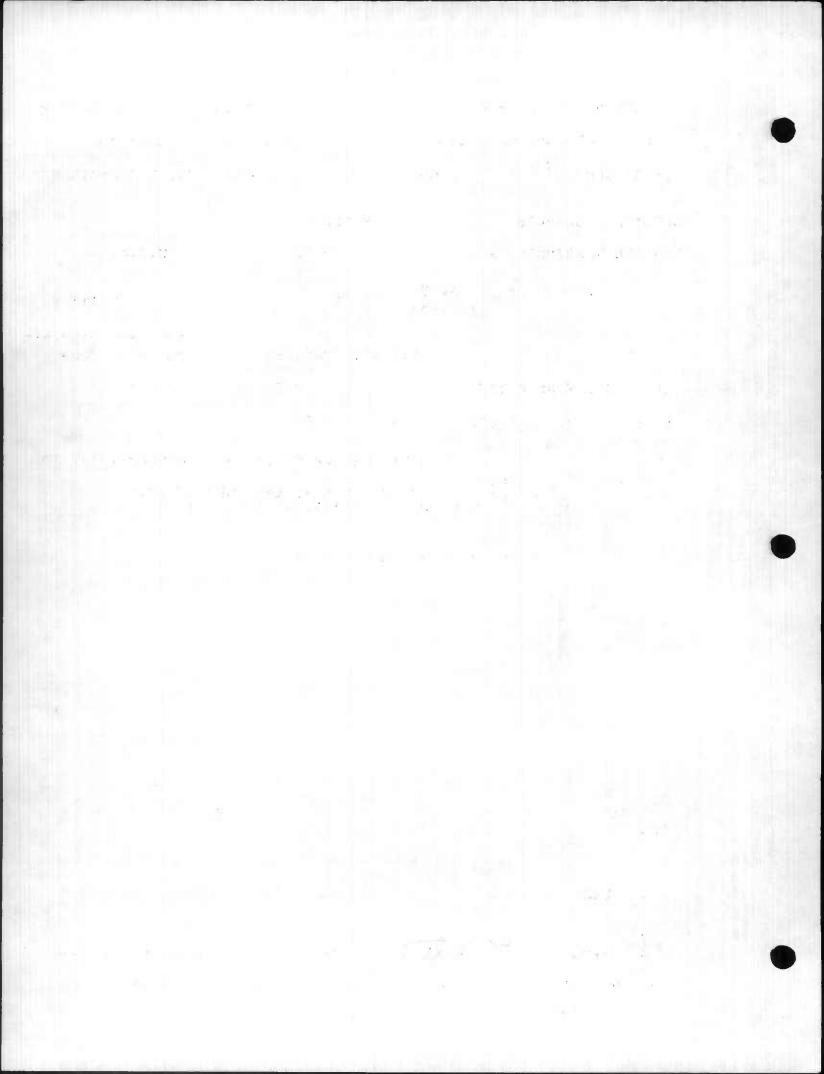
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permit. Page Department important: If important: If any injury or once.	2	21. Signature of Funeral Service Licensee MOO479 22. Name end Address of Fecility RAYMOND FUNERAL SERVICE, P.A.												
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or Attending effer death. Director: After 3 in by the fune	=	4 Homicide determined	building, e	c. (Specify)	m, street, lactory, onlo		City or Town							
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To the Hospital or A within 24 hours effer To the Funeral Direction Completely filled in Direction Certification C		b. Signature end title of certifier			29c. Lice	nse number	2	9d. Date signe	d (Month, Day,	Year)				
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	30	. Name and eddress of person who	completed ceuse of	deeth (Item 23a) (.0332		malCN	14, 2	000				
	30	Krishan Math				La Plata	. MD	20646	5					
State	31	. Date filed (Month, Day, Year)	32. Regist	rar's Signeture				_ 0 0 1 (
Registrar		MAR 15	2000	epera	D. Space	Kal								

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 2000 KRUG /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) April 13,1922 5. Social Sacurity Number 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months Days 77 Yrs. 079-18-0443 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 1 Yas 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 234 200 Civic Ave 21804 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: 1 Navar Married 2 Married 8 Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electronics Worker Electronics permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other
any Injury or other traum-17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Thomas A. Ahern Florence Lintner 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen F. Smith/Daughter PO Box 5175, Salisbury, MD 21802 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 3/8/00 22. Nama and Address of Facility Holloway Funeral Home Professional Association 21. Signatura of Funarai Service Licensee CFS 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ardiac anything Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): that initiated events resulting in deeth) Last Dua to (or as a consequence of): USB BS Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown after mellitus by Medical Certification: To Be Completed 24b. Were autopsy lindings 24a. Was an autopsy performed? available prior to completion of cause of death? After this certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No after deeth.

Diractor: After this certificad in by the funeral director, Physicien: 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours af To the Funeral Di 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier emil MD Joney

State Registrar

DHMH 16 Rav 6/95

Baitimore.

Box 68760.

P.0

Division of Vital Records.

100 POWER

ST.

SALISBURY

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

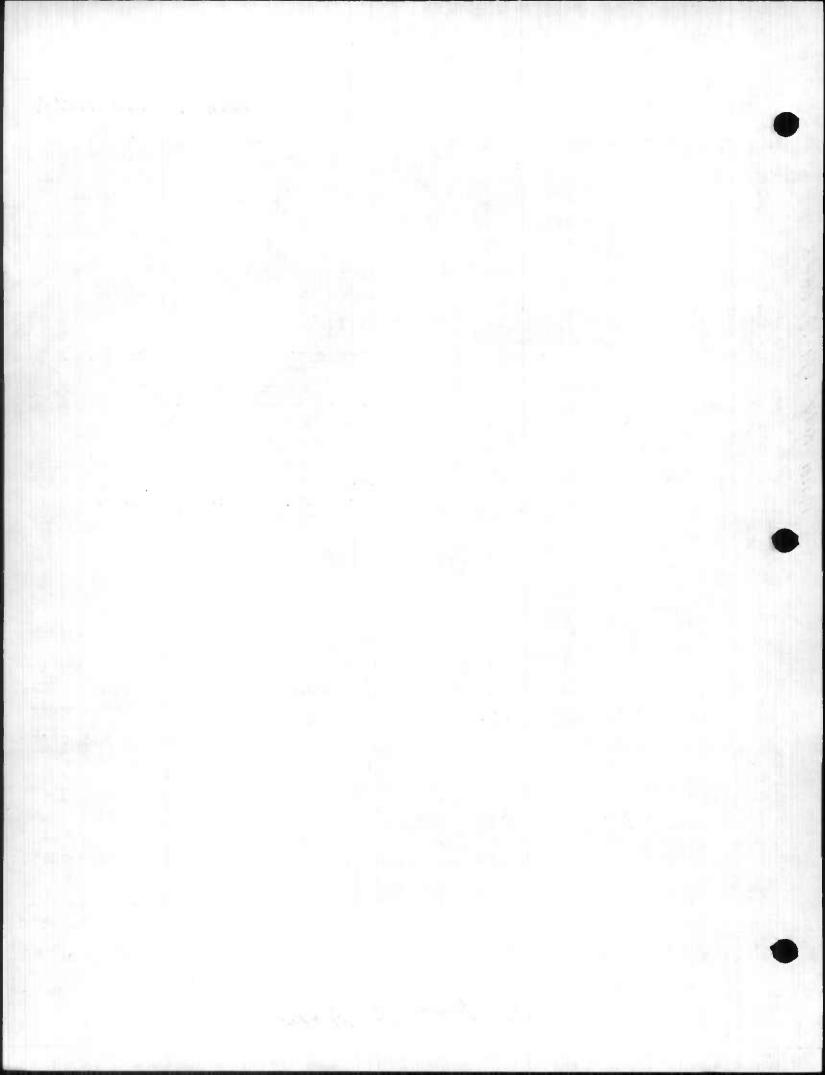
MAR 1 0 2000 >

WENRICH

32. Registrar's Signature

KODNE

31. Date flied (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Time of Death Year Month FEBRUARY 12 JOSEPH ADDISON KOLLOCK, 2000 1415 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of 1 .th PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 2□ F 221-18-8010 86 DEC 24, 1913 DELAWARE Usuel Rasidence of Decedant 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No DELAWARE SUSSEX DAGSBORO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P.O. BOX 68, VINES CREEK ROAD 19939 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 🕅 Married 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Dates: 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 POULTRYMAN POULTRY INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RAYMOND L. KOLLOCK MARY CAMPBELL 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) KATHLEEN CHANDLER KOLLOCK/WIFE P.O. BOX 68, DAGSBORO, DELAWARE 19939 20b. Plece of Disposition (Nama of cemetery, crematory or other place) 20a Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) PRINCE GEORGE'S CEMETERY 2/15 DAGSBORO. DELAWARE 21. Signeture of Flunerel Service Licensee 22. Neme end Address of Fecility
WATSON FUNERAL HOME, INC. Walson Reckard 211 WASHINGTON STREET, MILLSBORO, DELAWARE 19966 23a. Part1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory arrast, shock, or heart teilura. List only one cause on each line. Approximate Interval Betwe Onset and Dec Immediate Cause (Final 14 7 POXIL ENUE PIX ALUPATITY

Due to (or as a consequence of): diseesa or condition resulting in death) Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last PNEUMONAE Due to (or as e consequance of) 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Department of Health and Mental Important: If New 27 Is marked or any Injury or other traumatic events.

Physician

/Medical

Examiner

Funeral

Director

ma 23a or 28a-f ahow

Norma 23a

natural, or

altimore, Maryland 21215-0020

8010

231-18

65CPH

Director

Funeral

Completed

Physician/Medicai à Completed Be

68760, signed by the a Records, Vital Medicai Certification: To 5 a Hospital or Attending Pi 24 hours after death. Funeral Director: After the Division To the Hospital of within 24 hours a To the Funeral D completely filled it

Pert II. Other algrificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Was case referred to medical axaminer? 1 ☐ Yes 2 No 27. Manner of Deeth Natural 5 Pending 1 Yes 2 No investigetion 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide

29b. Signeture and title of certifier

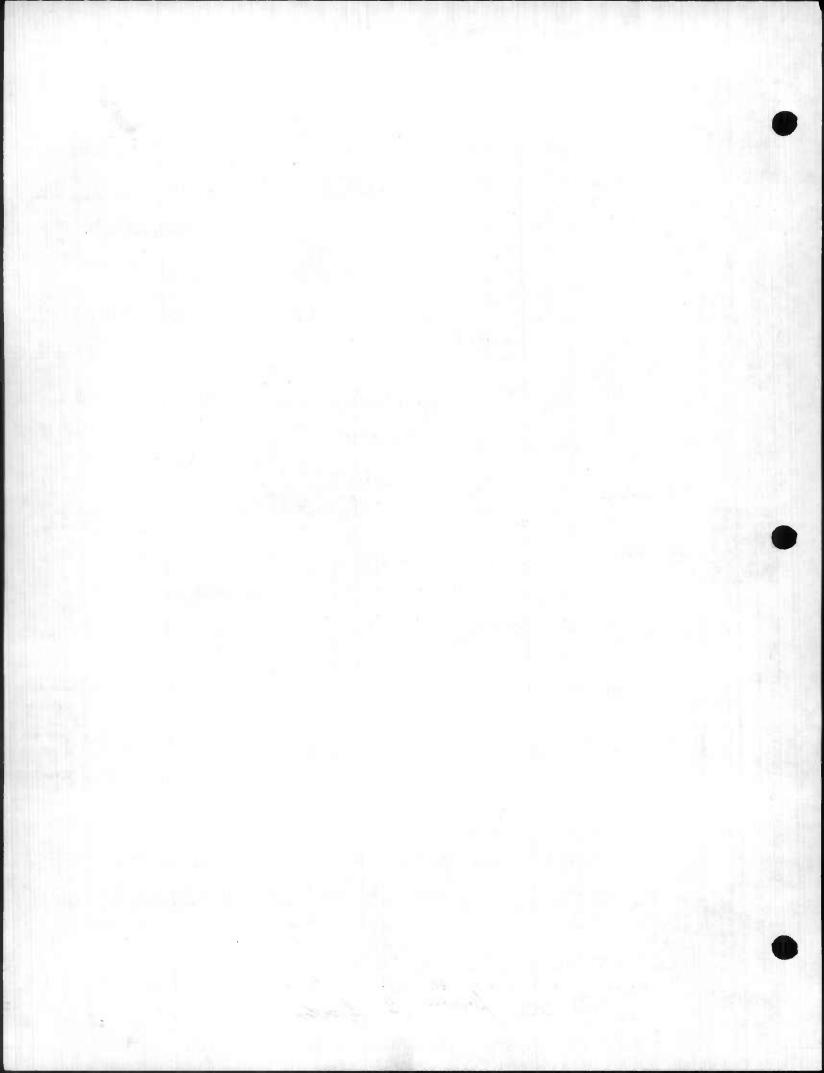
1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data end place, end dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner steted. 29c. License number 29d. Dete signed (Month, Day, Year)

30. Neme and address of person who complated cause of deeth (Item 23e) (Type, Print)

Dr. Dennis Chadnicki 400 factory Shore Drive, Salisbury Md. 21801 32. Registrar's Signature 31. Dete filed (Month, Day, Year) FEB 16

State Registrar 29a. Certifier



Please Type or Print in Black Indelible Ink. Assure All Copies Are Leable

tate of Maryland / Department of Health and Mental Hygiene	00691
Certificate of Death Reg. No.	03004
2. Date of Death	3. Time of Death

	1. Decedent'e Nam	e (First, Middle	, Last)
Physician /Medical	CLARA	VIR	GINIA
Examiner	4a Fecility Name (If not institution	, give street al
	SALISBUR	Y CENTE	R: GEN
Funeral	5. Social Security N	lumber	6. Sex
Director	226-12-2	2662	1□M 2X
-	Usual Residence o		
0 M	10a. State	10b. County	
Mad in the start	Maryland	Wicor	nico
rec ing	10e. Street and Nu	mber	
Ela o	30735 01	d Fruit	tland R
020 un aher deat al', or here: Examiner m by Funer	11. Marital Status 1 Never Marr 3 Wildowed		12. Was Arm 1 1 1 If Ye Yea
72 ho 72 ho dical	(Spec	15. Decedent	's Education
2121 od within rgiens. er then f. the Me	Elementary/Second 11	ondary (0-12)	Coll
De Me me	17. Father's Name	(First, Middle, I	Lest)
ylan Mental Ment	William	n F. Wil	lliams
ary and	19a. Informant's N	ame/Relations	nip <i>(Type, Prin</i>
N Sala	George F	Killian,	/Son
more, Maryland 21215-002(Pages 1 and 2 should be filed within 72 hours a vert of Health and Merual Hygiens, not it fleen 27 to marked other than "netural", or ry or other traumatic event, the Medical Exact To Be Completed by	20a. Method of Dis 1 XBurial 2 4 Donation	Cremation	
Balti Permit. Departri Importa any inju	21. Signature of Fu	meral Service (iospano /

n al	CLARA VIRGINIA KILLIAN FEB. 27, 2000 9:10 AM													
er	4s Fecility Name (h SALISBURY				DERCARE			4b. City, To			eath		y of Death	
	5. Social Security Number 226-12-2662 Usual Residence of Decedent				Age (In yrs. last birthday) If Under 1 Ye. Months Day				Min.	8. Date of (Month) June	Day,			place (State or Foreigntry) rginia
tor	10a. State Maryland		y, Town or Location 10d Salisbury							10d. Inside City Limits				
Funeral Director	10e. Street and Number 30735 Old Fruitland Rd.					10f. Zip Code 10g. Citizen of What Co								ntry?
à	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed	ed 2 Married	12. Was Dec Armed F 1 Yes If Yes, G Year or I	orces? 2 M No live	er in U,S.	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify: 11. Race - American Indian, Black, White, etc. Specify: White						etc.		
9190	(Spec	15. Decedent's ify only highest	Education grade completed)	(0	16a. Decedent's Usual Occupation (Give kind of work done during most of working					16b. Kind of Business/Industry			
Completed	Elementary/Secon	ndary (0-12)	College	(1-4or 5+)		Nousewife				Domes				
99901	17. Father's Name (William						(First, Mid Lassi		aiden Surna	me)				
	19a. Informant's Na George K			Aeiling Address					-					
	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State				20b. Place of D	rematory or o	ne of other pi	Date 20c. Location - City or Town, State				own, State		

4 ☐ Donation 5 ☐ Other (Specify)

22. Name and Address of Facility
Holloway Funeral Home Professional Association

23. Pa 11. Enter the disease, or con

501 Snow Hill Rd., Salisbury, MD 21804 complications that county the death. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

ALZHRIMERIS DISENSE

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II.	Other significant conditions	contributing to death	but not resulting In	the underlying caus	e given in Part

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed?

1 Yes 2 No

Was case	to	medical
examiner?		

31. Date filed (Month, Day, Year)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 □ DOA 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

29a. Certifier (Check only Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and liftle of certific

29c. License number 9813 29d. Date signed (Month, Day, Year) 00

of person who completed cause of death (Item 23a) (Type, Print)

M, ATK, NS M

MAR 0 1 2000

1104 HEALTHWAY DR., SALISBURY, MD. 21804 32. Registrar's Signature

State Registrar

Medical Certification: To Be Completed by

completely filled in by the funeral director,

Physician

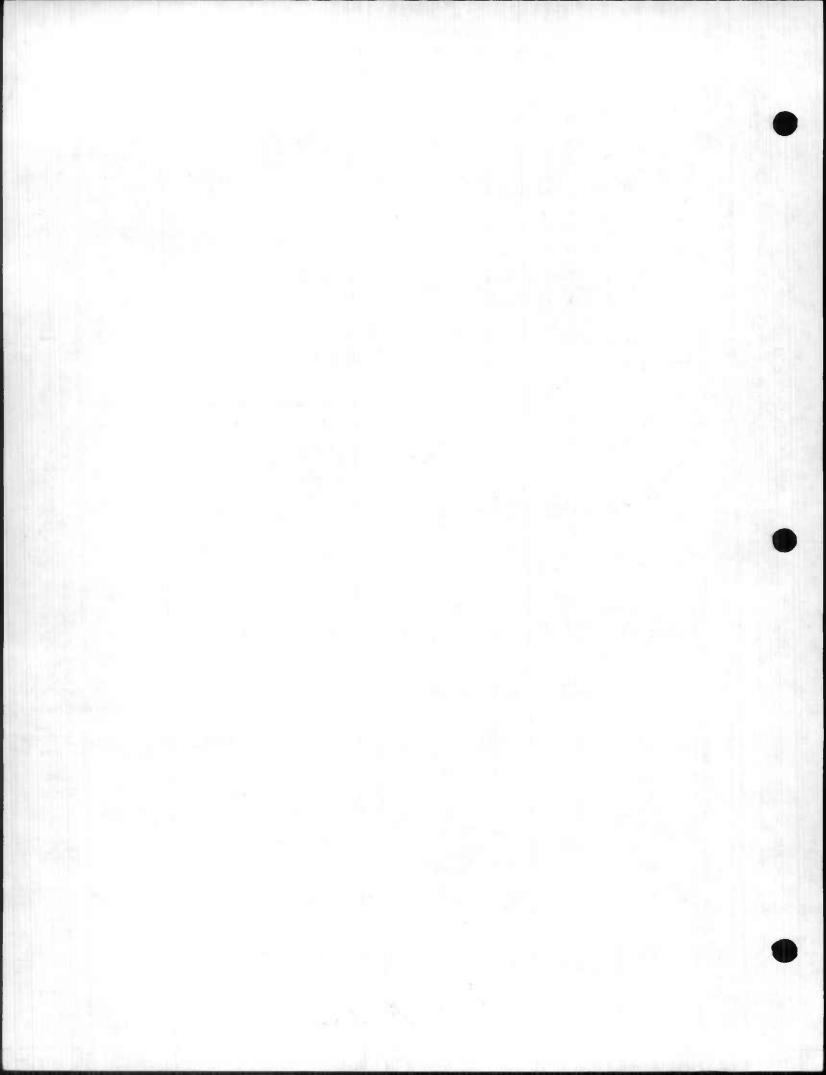
/Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be associed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

ate has been signed by the attending physician end page 2 should be detached for use as the burial-transit

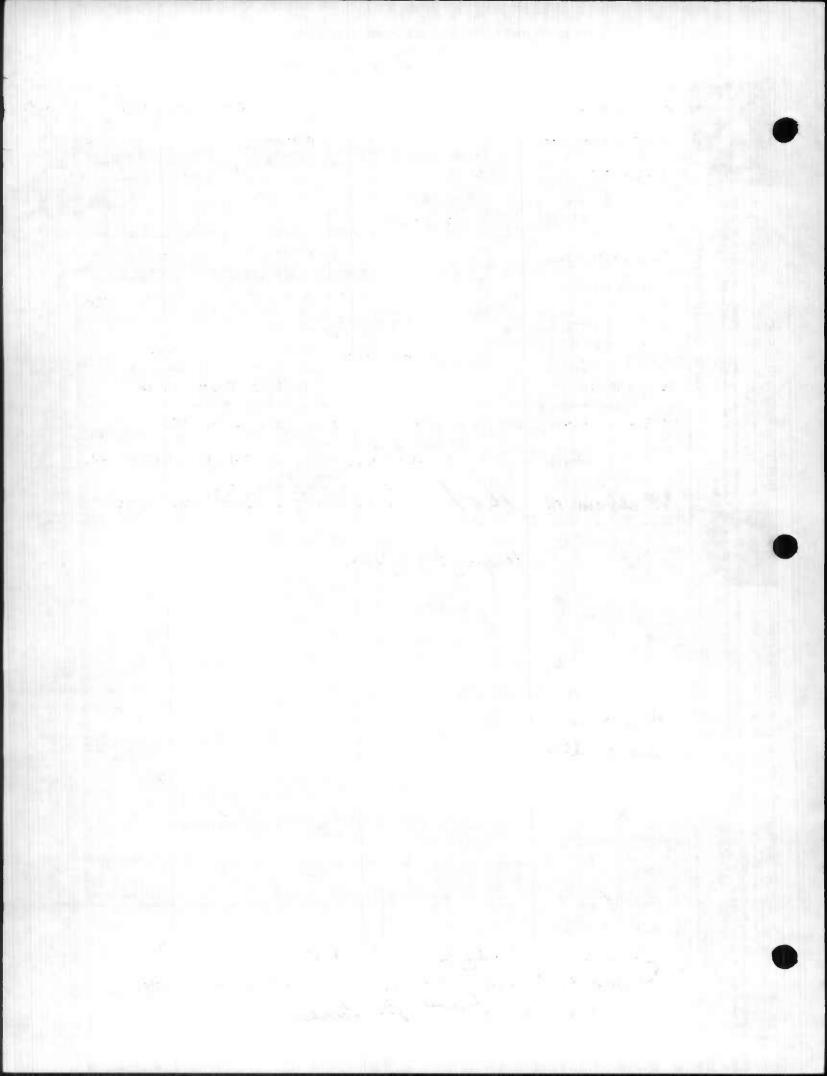


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day **Physician** Mary E. Kline Feb. 2000 7:00 A.M. 16, /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Wicomico 27686 Waller Road Salisbury 5. Social Security Number If Under 1 Yeer if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthdey) **Funeral** 1 M 2XX Months Days Houra Min Yrs. 3-30-1939 60 Md. **Director** 218-34-3334 Usual Residance of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or itams 23a or 28a-f show addes Examiner must be notified at 1 ☐ Yes 2 No Director Md. Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a and Injury or other traumatic avant, the Medical Example Institute. 27686 Waller Road 21801 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No tf Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: þ 3X Widowed 4 □ Divorced White Completed 16a. Dacedant's Usual Occupetion 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use ratired) Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father'a Name (First, Middle, Last) Joseph Ennis Madiline Crouch Ennis 19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William J. Cooper, Son Rt. 2 Box 336H Laurel, De. 19956 20b. Place of Disposition (Neme of cemetary, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Melsons Cemetery 2-18-00 Delmar, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each fine. DE. 19940 Approximata Interval Batwean Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in daath) Coronary Artern Disease Examiner Due to (or as a consequence of): Examiner physician end the buriel-trensit The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical Due to (or as a consequence of) ettending p signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hyprotensia by 24b. Were eutopsy findings available prior to completion of cause of death? bluods 24a. Was an autopsy Completed s certificete has t 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: director, 25. Was casa rafarrad to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Natural 5 Pending 1 Yes 2 No death. olivector: A Invastigation 2 Accident 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletary filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number a livenso Attenda MD addrass of person who complated cause of seath (Itam 23a) (Type, Print) Dr. Snite Azori, Salishing, no 2150 A. CRICK, MO 560 Riveride en JANE 31. Date filed (Month, Day, Year) 7 2000 32. Ragiarar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		Certificate of Death	Reg. No.	02000			
	Decedent's Nama (First, Middla, Last)		2. Data of Death Month Day Year	3. Time of Death			
Physician /Medical	Mae Kathryn Kilby		March 7, 2000	10:54 pm			
Examiner	4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or Lo	ocation of Death 4c. County of De	ath			
48	Washington Adventist Hospital	1 Takoma P	ark Montgo	omery			
Funeral Director	5. Social Security Number 202-24-6547 6. Sex 1 M 2 X F 67	last birthdey) If Under 1 Yaar If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Year)	irthplace (State or Foreign Country) ennsylvania			
¥	Usual Rasidenca of Dacedent 10a. Stata 10b. County 10c. Cit	ty, Town or Location		10d. Inside City Limits			
with the Maryland is or 28a-f show the notified at	Maryland Prince George's	District Heights		1 ☐ Yes 2 No			
in with the Me 23s or 28s-fr wat be notifier	10e. Street and Number 1845 Tanow Place	10f. Zip Code 20747	U.S.A.				
21215-0020 d within 72 hours after deam videos. In the Medical Examiner must	3 ☐ Widowed 4 ☐ Divorced If Yas, Giva Yaar or Datas:	J.S. 13. Was Decedent of Hispanic Origin? (Sp If Yas, specify Cuban, Mexican, Puerto 1 □ Yas 2\(\tilde{\text{\Lambda}}\) No Specify:	Sanite	nerican Indian, nita, etc. hite			
72 ho	15. Decedant's Education (Specify only highast grada complated)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	lent's Usual Occupation 16b. Kind of Business/Indu				
21 Men man	Elementery/Şeçondary (0-12) Collega (1-4or 5+)	(Giva kind of work dona during most of work lifa. DO NOT use retired)					
1 2121 led within tygiens. wer than it, the Ma	12	Accounts Receivable	Stockbr	oker			
Maryland 2 should be flie th and Mental Hy 7 is marked othe traumatic event		18. Mother's Name	a (First, Middle, Maiden Sumama)				
Via Wanter	Frank Schmeltz	Sarah	Seville Klinger				
S S S S S S S S S S S S S S S S S S S	19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Run	al Routa Number, City or Town, State	, Zip Code)			
C 21 44 F	Herbert Kilby - Husband	1845 Tanow Place, Dist					
Saltimore, emit. Pages 1 a Appartment of Hea reportent: If Nem iny Injury or othe	1 La Burial 2 Li Cramation 3 Li Hamoval from Stata	Place of Disposition (Nema of commatary, crematory or other place) National Memorial Park 3	Data 20c. Location - City of 2000 Laure1, 1				
Balti permit. Departm Importa any inju	21. Signatura of Funeral Sarvice kicensaa	22. Nama and Addrass of Facility Gasch's Funeral Hom	e, P.A.				
	23a. Part1. Entar the disease, or complications that caused the dael shock, or heart failure. List only one cause on each line.	4739 Baltimore Aven	ue, Hyattsville,	MD 20781 Approximate Interval Between			
Examiner Examiner	Due to (d	or as a consequence of):	1(-14/7)				
6876(ficate be physicia is the bur	Cause (Disease or Injury that initiated evants rasulting in death) Last	or as a consequence of):					
Box eath cert attendin Ifor use	d			1			
P.O. d by th detached		iulting in tha undarlying causa given in Part I.	23b. Did tobacco use contribu	re to the cause of death? Probably 4 X Unknow			
II RECORDS, P.O The law requires that tha tate has been signed by th page 2 should be detech Completed by Phys.			24a. Was an autopsy performed?	b. Were autopsy findings available prior to completion of cause of death?			
I 9 6 6			1 ☐ Yas 2 No	1 Yes 2 No			
certificate irector, pag	25. Wes casa referred to medical	26 Place of Deal	th (Check only one)				
	axaminar?	Other	oma 5 Residence 6 Other (Sc	necify)			
VISION OF Attending Physic death. ector: After this by the funeral of iffication: To	27. Mannar of Death 1 Matural 5 Panding (Month, Day Year) 2 Accident invastigation	28b. Tima of thijury M 28c. Injury at Work? M 1 Yas 2 No	28d. Describe how injury occurred	youny)			
ma 6 2 5 6	3 ☐ Suicida 6 ☐ Could not be determined 28e. Placa of Injury - At h building, etc. (Special Could not be determined 4 ☐ Homloida	oma, farm, street, factory, office fy)	28f. Location (Street and Number or City or Town, State)	Rural Route Number,			
n 24 hound		owledga, death occurred at the tima, data and place, stion and/or invastigation, in my opinion, deeth occur					
within To the Comp	29b. Signatura and titla of certifiar	29c. License number	29d. Date signed (Mo	onth, Day, Year)			
	111 rah	133942	- HOTI.	2000			
(4)	30. Name and oddrass of person who completed causa of death (Iter	n 23e) (Type, Print) 7253 B H a	morer farlew	an Corcer			
State	31. Data filed (Month, Day, Year) 32. Registrar's Signa	atura	V1001-1 1001-10	7			
Registrar	MAR 0 9 2000 Sehene	A. load.					

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Lena Kalla March 8,2000 4:45AM 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Spa Creek Nursing Center Annapolis Anne Arundel If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Hours Months Davs 10 M 25 F 579-07-2756 83 March1, Pennsylvania Usual Rasidence of Decedent 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits MD Anne Arundel Edgewater 1 ☐ Yas 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 United States 601 Barton Road 13. Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 22 No If Yes, Give 11 Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ TYO Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada complated) Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Saglimbene Mary Giacone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Relationship (Type, Print) Gloria J. Beard (DAUGHTER) 1249 Shore Drive, Edgewater, Maryland 21037 20a. Method of Disposition

1 Deurial 2 Cramation 3 Removal from Stata 20b. Plece of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, State 3/11/00 Washington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signeture of Funeral Service Licensee 22. Nama and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part ff. Other aignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760. P.O. Division of Vital Records,

physician the burial 88 USB certificate or Attending Physician: After this within 24 hours after deeth. To the Funeral Director: A Hospital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician

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Physician/Medical

Completed by

Be

72 hours after

Baltimore, Maryland 21215-0020

edical Certification: To completely State

Registrar

29b. Signeture and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

MAR 0 9 2000

29a. Certifier

(Check only one)

Sprare

2108 Dr. Dont Parise Che La MO21619 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Data signed (Month, Day, Year)

032036 3/8/00

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		10c. Ci	y, Town or Lo	ocation							1	0d. Inside City Limi			
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	ro Rd. #	617		10f. Z		735		10g. Crizer				itry?			
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		4	Reg	ister	ed N	Vurse	e Nursing								
7. Father's Name (First, Middla, Las	t)							3.1			ma)	na)			
James Michael H	ennessy					Be	rtha	E. Ta	y10	r					
19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street	t and Numb	er or Aur	al Routa Num	ber, Ci	ty or Town	n, Stata, Zip	Code)			
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29a. Certifiar (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
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(Check only 2 Medical Exa	miner: On the ba	ner stated.		0.00	on Linea	ea number			204	Data cion	ed (Month	Day Yearl			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** PHILIPA B. KALOKOH 1748 MARCH 2000 5 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Dey, Year) February 17, 2000 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 17 Hours 1 ☐ M 2 X F Mary Land Director N/A Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Prince George's Riverdale Directo Nems 23s or 28s-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5309 Riverdale Road, #615 20737 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. hours after 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 abouid be filtered to the second be filtered by and Mental H anti: If Item 27 is marked off lary or other traumatic even 88 Philip A. Konteh Mariatu Kalokoh 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip A. Konteh/Father 5309 Riverdale Rd. #615, Riverdale, Maryland 20737 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 03/08 20c. Location - City or Town, Stete 1 ABurial 2 Cremation 3 Removel from State Department of Important: If any injury or anse. Resurrection Cemetery 2000 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** SEVERE INTRACRANIAL HEMORRHAGE /Medical Immediate Cause (Finel 15 days disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner EXTREME PREMATURIT sician and burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical Due to (or as a consequence of): 88 180 signed by the a 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 1 Yea 2 No 3 Probably 4 Unknown NIL Division of Vital Records. þ 24b. Were autopsy tindings available prior to 24a. Was an eutopsy performed? completion of cause of death?

The law requires page 2

this funeral after death.

Completed Be 25. Was case referred to medical examiner? 10

Hospital of \$ State Registrar

2

filled in

or Attending

27. Manner of Death Certification:

within 24 hours a To the Funeral C completely filled

29b. Signature and little of certifier M. Sukuman

MD

28a. Date of Injury (Month, Day Year)

29c. License number 53354

28c. Injury at Work?

1 TYes 2 TNo

13 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) March 5, 2000

1 ☐ Yes 2 ☐ No

20850

1 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

2 No

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 MEDICAL CENTER DRIVE ROCKVILLE MD MD Dr M. SUKEUMAR

31. Date filed (Month, Day, Year)

1 Yes 2 No

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

MAR 0 8 2000

5 Pending

investigation

6 Could not be

32 Registrár's Signature

1 Prinpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

VITTE II - SELL SHEELS

Em Salarande M.

Can table on Summers

MAR 0 0 2000 James & James

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State of Maryland / Department of Health and Mental Hygiene

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Physic		1. Decedent's Name (First, Midd Theodore	E.	Ke.	llogg						2. Dete of De Month	eeth Day	Year		ime of Death
/Medi Examir		4e. Fecility Name (If not Institution					_	1		wn, or Lo	March cation of Deal	inty of Death	h	00 A.M	
Funeral Director		Fairview Home 5. Social Security Number 224- 38-9194	For th	7. Age	(In yrs. last b	oirthdey) Yrs.	If Under Months	1 Yee Deys			(Month, D	8. Dete of Birth (Month, Day, Year) Oct 15, 1935 Prince George's 9. Birthplace (State or Foil Country) Virginia			State or Foreign
Marylend f show ed at	or	Usual Residence of Decedent 10e. State 10b. County MD PG	,		10c. City, To For		cation 7ille				10d. Inside City Limits 1 ☐ Yes 2 X 1				
th with the Mar 23e or 28e-f si	I Director	10e. Street end Number 5508 Stoney M	eadow T	rive			10f. Zip	Code	7			10g. Chizen Unit	of What Cor ed Sta		
ter dee Herms	by Funeral	11. Maritel Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. We Arn	as Decedent Evned Forces? Yes 2 No 'es, Give er or Detes:		1	Was Deced I Yes, spec	cify Cul	ben, Mexican,	gin? (Spe , Puerto	ecify Yes or Ne Rican, etc.)		Rece - Amer Black, White poify:		
21215-0020 d within 72 hours at giens. It than "natural", or the Would I have	Completed	(Specify only highe	nt's Education st grade comp	eleted)	16	(Give	lent's Usua kind of wor DO NOT us	rk done	during most	of work!	ng	16b. Kind o	b. Kind of Business/Industry		
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T Sale	Be	17. Father's Name (First, Middle, Theodore R. Ke									(First, Middle e Will		neme)		
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X D8/ DU, entificate be assected ling physician and eas the burlet-frensit	Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest	6	Di	ue to (or es e ue to (or es e ue to (or es a	conseq	uence of):	dia	beles	7					
death c	Physician/	Part II. Other significant condition	d	g to death but	not resulting	in the ur	nderiying ca	ause gi	ven In Part I.		23b. Did	tobacco use	contribute	to the cr	nuse of death?
requires that the reen signed by the hould be detached	by Phy										10	Yes 2□N	o 3□Pro	bably	4 Unknow
2 s s	Completed										24a. Was	an eutopsy ormed?	a	vallable p	opsy findings prior to n of cause
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_ 2 10 73	To Be	examiner?	Hospital	1 Inpatient	2 DER/0	utpetient	3□ DO	A Ot	hor \		(Check only only only only only only only only		Other (Spec	ifv)	
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5 th to		4 ☐ HomicIde determ	ined 288.	Place of Injury building, etc. ((Specify)						8f. Location (City or To	wn, State)			Number,
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To the To the Comp.	M	29b. Signature and title of certified	Hilps	0				29c. License number 29d. Date signed (Month, Dey, Year) 3-8-2000							
(12)		30. Name and eddress of person Wavell C. Hoo					Print)			,					
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				Certifica	ite of	Death	•	Reg. No.	0 0		
Physician	Decedent's Nama (First, Middla, I	.ast)					2. Date of D Month			3. Time of Death	
/Medical	Henry Eric Kur	tenbach					Marcl	n 7th		9:25am	
Examiner	4a Facility Name (If not institution, g	ive street and number))				r Location of Dea	,			
	NIH					Bethesda		Montgo			
Funeral Director	5. Social Security Number 6 100–42–9295	Sax 7. Ag	ga (In yrs. last bi 49	Month	er 1 Year S Days		n. 8. Data of B	irth lay, Year) 1950	9. Birthplai Country New	ce (Stata or Fore York	
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itsms 23s or 23s-f short inst.must.be.notified.st funeral Director	7 Keiths Lane			039	Cip Code			10g. Citizen of 1 United		,	
r Harra 3	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Dec	Decedent of Hispanic Origin? (Specify Yes or as, specify Cuban, Mexican, Puerto Rican, atc.)			lo- 14. Rac	ce - American		
by F	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yas 2 If Yas, Giva Yaar or Datas:		10 111-11	Yes 2√ No Specify:				Whit		
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To B	Henry W Kurtenba	ch				Sylvia	L. Worm				
	19a. Informant's Name/Relationship	(Type, Print)	198	. Mailing Addra	ss (Street	and Number or	Rural Routa Num	ber, City or Town,	State, Zip C	Code)	
the tra	Mrs. Coleen Kurt	enbach	7	Keiths	Lan	e, Eliot	ME 0390	03			
50	20a. Mathod of Disposition		20b. Place of Disposition Commetery, crema			(ne)	Data	20c. Location -	City or Town	n, Stata	
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ortent: If injury or B.	21. Signature of Funeral Sarvice Lic		1			ess of Facility	1				
on one	1	1/		Rapp	Fune	ral & Cr		Service	5		
	Xamal.	Vardesty		933 (ist	Ave Silv	ver Spri	ng Md			
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the fe	2 ☐ Accident invastigat			М	1	Yes 2 □ No					
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Me Me	29b. Signatura and titla of certifiar			2	9c. Licens	se number		29d. Date signs	d (Month, Di	ay, Year)	
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/	30. Name and addrass of person who										
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State	31. Date filed (Month, Day, Year)	. Registr	rar's Signature								
egistrar	MAR 1 0 2000	Denve	ar 19.	Spa	11						
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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Christian Jesus Leveron February 3:10 am 2000 28 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Ame Annales Medical Center 2001 Medical Partway Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) **Funeral** N/A 9 Feb. 19,2000 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 1 Yas 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be 1013 President Street "netural", or flams 23s 21403 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0020 XX Yes 2 No Specify: þ 3 Widowed 4 Divorced El Salvadoran Hispanic 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Etementery/Secondary (0-12) College (1-4or 5+) N/A N/A parmit. Pages 1 and 2 should be liled.
Department of Health and Mertal Hygie Important: if Isan 27 is marked other 1 any injury or other traumatic event. In 17. Father's Name (First, Middle, Last) 18 Mother's Nama (First Middle Maiden Sumama) Be Pedro Alfonso Leveron Ena Rivera 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pedro A. Leveron/ Father 1013 President Street Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slata 1 D Burial 2 Cremation 3 Removal from State Hillcrest Cemetery 3-1-00 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final da disease or condition resulting in death) Examine Examiner mina physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Box 68760. eme certificate be Physician/Medical that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen has 1 Yas 2 Nac 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? 89 26. Place of Deeth (Check only one) Hospital: 1 Ampatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and mannar steted. Medical 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28 47158 H.D 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yann-Yann Lin, MD 2001 Medical Parkway Amapolis, MD 21401 31. Date filed (Month, Day, Year) 32/Registrar's Signature State MAR 0 1 2000 Registrar

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	Funeral Director		5. Social Security Number 214–20–7216 Usual Rasidance of Decedant	8. Sax 15₹ N	7. Ag		last birthday) 38 Yrs.	If Under 1 Yaer Months Days		8. Dete of Birth (Month, Day Oct. 25	, 1911	9. Birthp Coun MI	ace (Stete or For try)	reign
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Na Na		То	Leonard Georg	e Lino	lenmeyer				Myra V	Wallace	Donoho			
a	and and and		19e. Informant's Name/Relation	nship (Type	, Print)		19b. Mailir	ng Addrass (Straa	t and Numbar or Ru	ral Routa Numbe	r, City or Town,	Stata, Zip	Code)	
	CINE		Carolyn A. L	utz/Da	ughter		1561	Putty I	Hill Ave.	Tows	on, MD	21286)	
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Baltimore,	permit. Pages Department or Important: If I eny injury or once.		22. Nema and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral 1 495 Gov. Ritchie Hwy. Severna Park, MD 2114											ome
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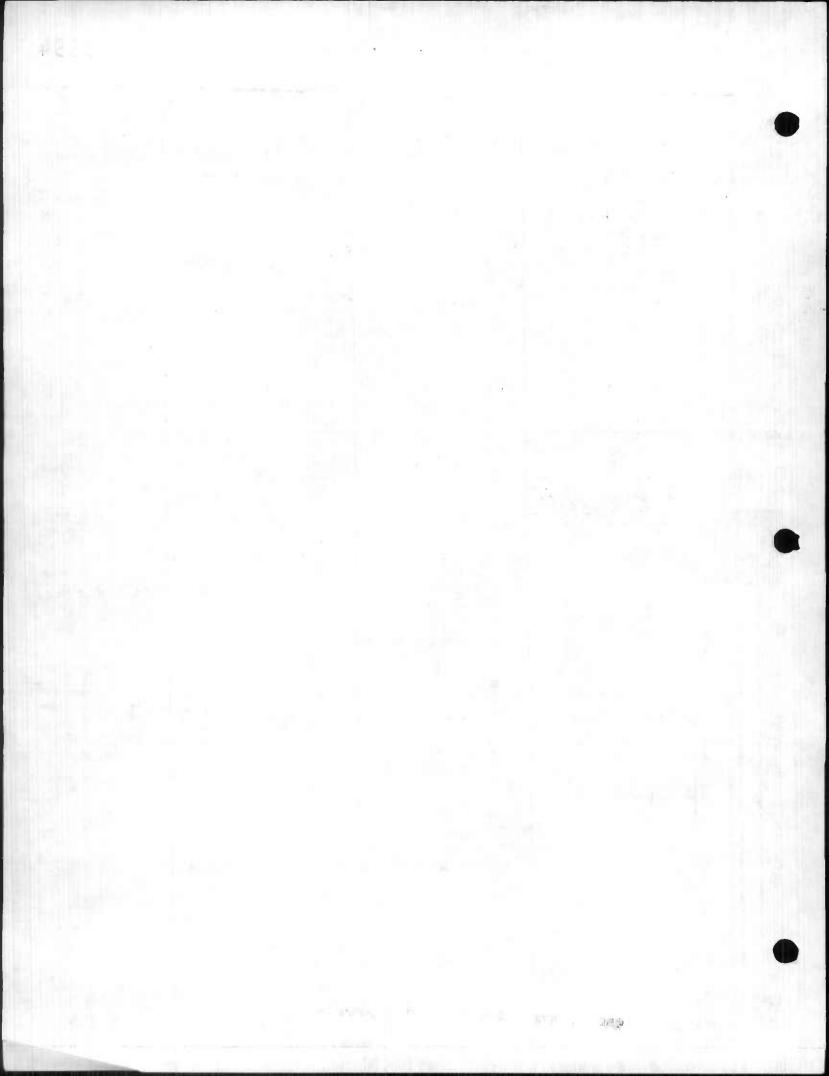
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State of Maryland / Department of Health and Mental Hygiene 00 09694

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	Physician	CARL H. LEVERENZ				Month MARCH	9 2000						
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	Funeral Director	070-10-3130 /		last birthday) 7 3 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 6-14-2	Year)	9. Birthp Coun	lace (State or Foreign try) NY			
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7	illed vigo	17. Father's Name (First, Middle, Last)	4	I PRO	FESSOR	18. Mother's Nam	e /First Middle						
	ental H ked off		Е Ноиск										
2	and Me meri	19a. Intormant's Neme/Reletionship (/ERENZ	19b. Maitir	ng Address (Stree	t and Number or Rus			State, Zip	Code)			
Baitimore, Ma	alth a 27 la r tra	NORMA LEVERENZ	7	41	MOONSHE	LL DR.	BERLIN,	Mp. 2	2181	1			
	of He	20a. Method of Disposition 1 ☐ Buriat 2 ☑ Cramation 3 ☐		Place of Dispo	sition (Name of matory or other pla	ice)	Date	20c. Location -	City or To	wn, State			
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Dail	Depart Depart Import any Inj	21. Signaturing Funtinal Service Licenses 22. Name and Address of Fecility ULLRICH FUNERAL HOME BERLIN, MD. 21811 23a. Pårf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between											
x 68/60,	Medical Examiner of transit and a second of the purish and a second of transit	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cerebe Due to (or es a consequence as	quence ot):	Peter I	iosele	rolie		5 yrs			
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ords, P.O	that the dead by the detached	Part II. Other and it conditions contributing to death but not resulting in the underlying cause given in Pert I. Disease. Much light						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
	To the Hoopital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as Madical Certification: To Re Commission by Divisional Madical Certification.	CVA; Hypo Hypoidism						a. Was an autopsy performed?		ere autopsy tindings ailable prior to mpletion of cause death?			
Ĕ	The it	10					1 🗆 Y	es 2X No	10	☐Yes 2M No			
2	entifica ctor,	25. Was case reterred to medical examiner?				26. Place of Dea	th (Check only or	ne)					
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To the Hospital or Attending Physician: within 24 hours after death.	tal or Attending P. rs after death. al Director: After ti ed in by the funera	27. Manner of Death 1 Naturel 5 Pending investigation 3 Suicide 6 Could not be determined at the determined of the determined investigation of the determined at the determined of the determi								/ Route Number			
	ital or A	4 Homicide determined building, etc. (Specify)											
	in 24 hour in 24 hour he Funer pietely fill	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the Com	29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Day, Year)					
		Jugarus le (Delland 4. D 29505						3-10	7 - 7	2000			
	6+1	38. Name and andress of person who	completed cause of death (Item	m 23a) (Type,	Print)	Bose 7	2 50	esbeary,	MO	21801			
	State	31. Dete tiled (Month, Day, Year)	32. Fjeglstrar's Sign	ature L	- China	a right	1, 100	1	11/	21001			
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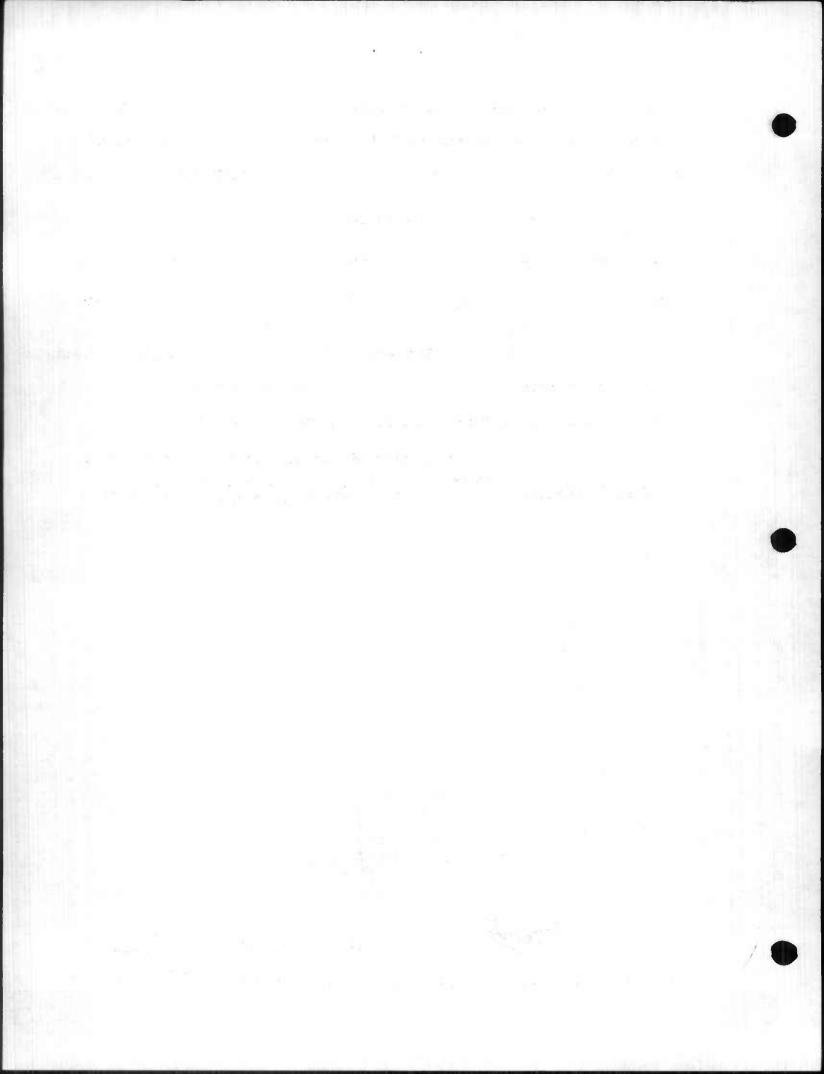
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 9 **Physician** Month James Frederick Linkenhoker 11:15 PM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Snow Hill Nursing & Rehabilitation Center Snow Hill Worcester 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplece (State or Foreign
 Country) **Funeral** 11 M 2□ F Deys 86 Director 232-16-4447 12/10/1913 West Virginia Usuel Residence of Decedent with the Marylend 10a. Stete 10b. County show 10c. City. Town or Location 10d. Inside City Limits maint be notified at Director 1 Yes 2□No 288-1 Worcester Pocomoke City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 23a or 105 Fifteenth Street 21851 USA deeth Funeral 12. Wes Decedent Ever In U.S.
Armed Forces?

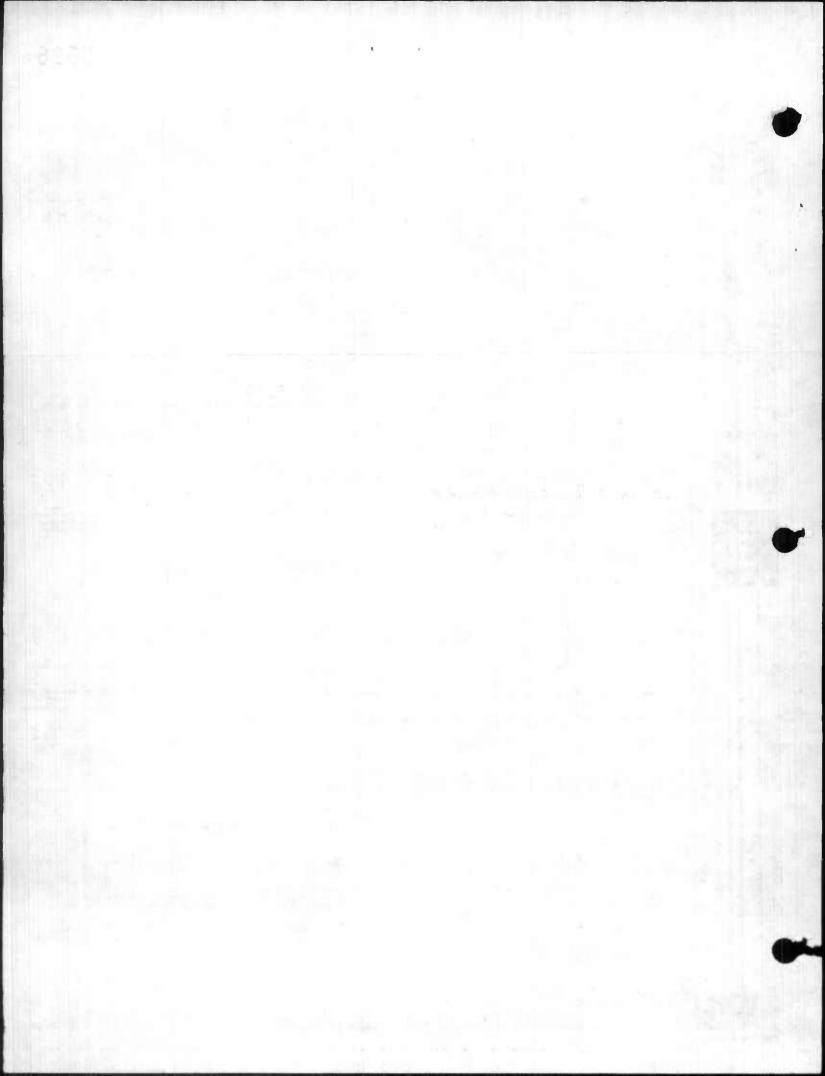
1 ॲYes 2 ☐ No
If Yes, Give
Yeer or Detes: ₩₩II Heme Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Rece - American Indian. permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examina page. Bleck, White, etc. 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 XWidowed 4 □ Divorced white Be Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Insurance Broker Metropolitan Insurance 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Linkenhoker 2 Lura Lee Conrad 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sandra L. Hickman (daughter) P.O. Box 310, Horntown, VA 23395 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Pocomoke City, MD 4 ☐ Donetion 5 ☐ Other (Specify) Bethany United Methodist Cem. 3/12/00 21. Signeture of Figneral Service Licensee 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. mo1129 ADean 103 Linden Ave., Pocomoke City, MD 21851 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final HVPOXIO disease or condition resulting in deeth) Examiner Ithmia; Arrh The law requires that the death certificate be executed bunel-transit Physician/Medical Exami Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest and Vulvular dis. anding physician a Box 68760, Due to (or es e consequence of): use es 0 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Dementia signed t Records, cate hes been signated by page 2 should b Completed 24b. Were autopsy findings evellable prior to 24a. Was an eutopsy performed? completion of cause of death? certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 70 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menger of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred After Division 1 Neturel 5 Pending investigation s after death.

I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital of within 24 hours at To the Funeral C completely filled 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end menner stated. Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D-0054422 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 0+1 Pocomoke, MD Market Street 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State MAR 1 6 Registrar



DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 6:40 PM ebruary 28, 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Roseda Hospita enter Mare more If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 ■ M 2 🕦 F 3 215-46-51 Usual Residence of Decedent Director 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehon 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 8 12. Was Decedent Ever in U.S.
Armed Forces?

1 | Yes 2 | Tho Nerns 23a 7862 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1□ Yes 2 No "natural", or Specify: þ 3 Widowed 4 Divorced filed within 72 hours Hygiene. Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mportant: If item 27 le marked other than any Injury or other treumatic event, the Man Etementery/Secondary (0-12) College (1-4or 5+) Me GRAGE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental ARINACCI ANTHON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Heelth : SON FRIEND eda 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location 6 Rosen 3-2-00 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility FUNERA 5 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and only one cause on each line. Physician 45 Minutes /Medical Immediate Cause (Final diseese or condition resulting in deeth) stol Examiner Physician/Medical Examiner Cardio Vascular Disease physician end the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): 980 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 X Yes 2 □ No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No or Attending Physicien: 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours efter death.

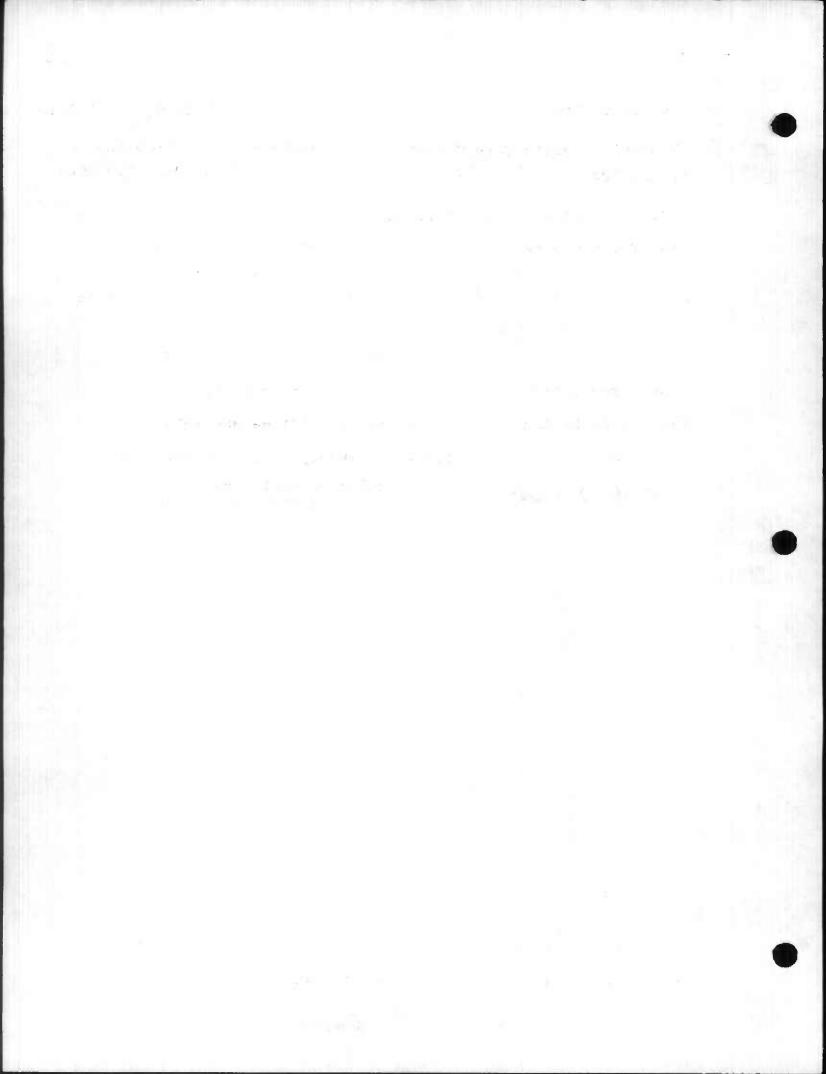
Funeral Director: A 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check of one) 29c. License number 29d. Date signed (Month, Day, Year) 28 2000 who completed cause of deeth Item 23a) (Type, Print) 9000 Square Drive Baltimore, Marylana ranklin MAR 0 8 2000 State Registrar

DHMH 16 Rev 6/95

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		Amended #17/02/2				rtment tificate			nd M		giene () (Reg. No.	0 (969	8
Physicia		Decedent'a Nama (First, Middle, Last)							2. Date of Dec Month	Day Year				
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anyland show dat	1	Usual Residence of Decedent 10a. State 10b. County Md. Wicomic			/, Town or Lo							1	0d. Inside Ci	
with the M Se or 28a-f	Funeral Director	Md. Wicomico Salisbury 10e. Street and Number 10f. Zip Coda 21801									10g. Citizen of What Country? U.S.			
urs urs	by	11. Marital Status 12. Was Decedant Evar Armed Forces? 15 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedant Evar Armed Forces? 1 Yea 2 Thought Year or Detes:			U.S. 13. Was Decedent of Hispanic Origin? (Sin If Yas, specify Cuban, Mexican, Puerto					pecify Yas or No- o Ricen, atc.) 14. Race - American Indian, Black, White, etc. Specify: White				
within 72 ho ene. than "natura ne Med call	Completed	15. Decedent'a Edu (Specify only highast grad			(Give :	6a. Decedent's Usuel Occupation (Give kind of work done during most of worldife. DO NOT use retired)			of workir	ng		Kind of Business/Industry		
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l and 2 leaith ar m 27 is		19a. Informant's Name/Reletionship (T) Marilyn Locke A 20a. Method of Disposition 1 Burial 2 Cramation 3 F 4 Donation 5 Other (Specify)	unt	CI		Box Stion (Neme netary or other	911 of ar place	Gai	nes	Pa. 1	6921 20c. Location	- City or To	wn, Stata	
permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funerai Sarvice Licens C 91/Enn/Essac	00	0416	Me	Nama and	Address F	of Facility uner	al 1	Home	2181			
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8 5 8	Completed by	SEIZURE DISORDER BRONCHIGI astuma.							24a. Waa perlo	. Waa an autopsy performed? 24b. Ware autopay finding available prior to completion of ceus of death?			0	
		BRUNCHIA1 25. Was case referred to medical	astin	9.				06 51	at Danth	101		10]Yes 2□	No
this ald	ation: To Be	examiner? 1 Yas 2 No 27. Manner of Death 1 Naturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28c. Injury et Work? 1 Yea 2 No					sing Hon	Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
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To th Withir To th comp	Me	29b. Signatura and fittle of certifiar CUALUMY 30. Name and address of person who completed cause of death (item 23a) (Type, Print) MAHESH MEONDEA 106 WITTERD 54 31. Date filled (Month, Dev. Year) 32. Registrar's Signature					icansa	number 2014	29d. Data signed (Month, Day, Year)					
		30. Name and address of person who co	ompieted cause of o	death (Item	23a) (Type, 1 4) / FOR	Print)	á	504 B	51	dissus	y ms	2/80	94.	
State Registra		31. Date flied (Month, Dey, Year) FFR 2.8.20		ar's Signat			~ no.	4 "						



Please Type or Print In Black Indelibie ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene \(\begin{align*}
\emptyset{\text{Proposition}}
\emptyset{\text{Pro Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LONG 2125 INEZ 3 00 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) October 19,1920 Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Deys Hours 10 M 20 F Yrs. 79 Tennessee 212-26-2167 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 N. Park Dr. 21804 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notr Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married 1 Yes 2X No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: White 3€ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) State of Maryland Claims Judge 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Cleveland Daugherty Callie Mae Hensley 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 121 N. Park Dr., Salisbury, MD 21804 Ronald B. Brantley/Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stete
4 Donetion 5 Other (Specify) 3/10/00 Salisbury Crematory Salisbury, MD 21. Signeture of Funerel Service Ligar 22. Name end Address of Fecility Holloway Funeral Home Professional Association Keeth 23a. Pert1. Enter the disease, or complications het caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Immediate Cause (Finel disease or condition resulting in deeth) Dichtim Due to (or as a consequence of): Examiner Direm Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): malling soped il Physician/Medical Due to (or es e consequence of): Nyze-lensin Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 2000 Be To

that the death certificate be executed Box 68760. P.O. 1 Records. Division of Vital al or Attending Physicien: T s after death. I Director: After this certificat of in by the funeral director, p. Certification:

e Hospital or A 24 hours after Funeral Directors pletaly filled in b

To the Hosp within 24 ho To the Fune completaly fi

Funeral

Director

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8 Items 23s

altimore, Maryland

Health and Mental

Department of Health Important: If Item 27

Physician

Allegical

Examiner

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25. Was case refer	rred to medical				26. Place of D	eeth (Check only one)				
axaminer? 1 ☐ Yes 2 ☑	No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DO	Home 5 Residence 6 Other (Specify)					
27. Manner of Deal 1 Neturel 2 Accident	th 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred ☐No				
3 Suicide 4 Homicide		28e. Plece of Injury - At h building, etc. (Speci	iome, ferm, streetly)	et, fectory,	office	28f. Location (Street and Number or Rurel Route Number City or Town, Stete)				
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29a. Certifier (Check only one)	1 ☐ Certifying Physician: To the best of my knowledge, deet 2 ☐ Medical Examiner: On the basis of examinetion and/or in and manner steted.		
29b. Signeture an	d title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)

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0.	Neme	and address of	person who	completed	ceuse of	death (Item 23a) (Type,	Print)

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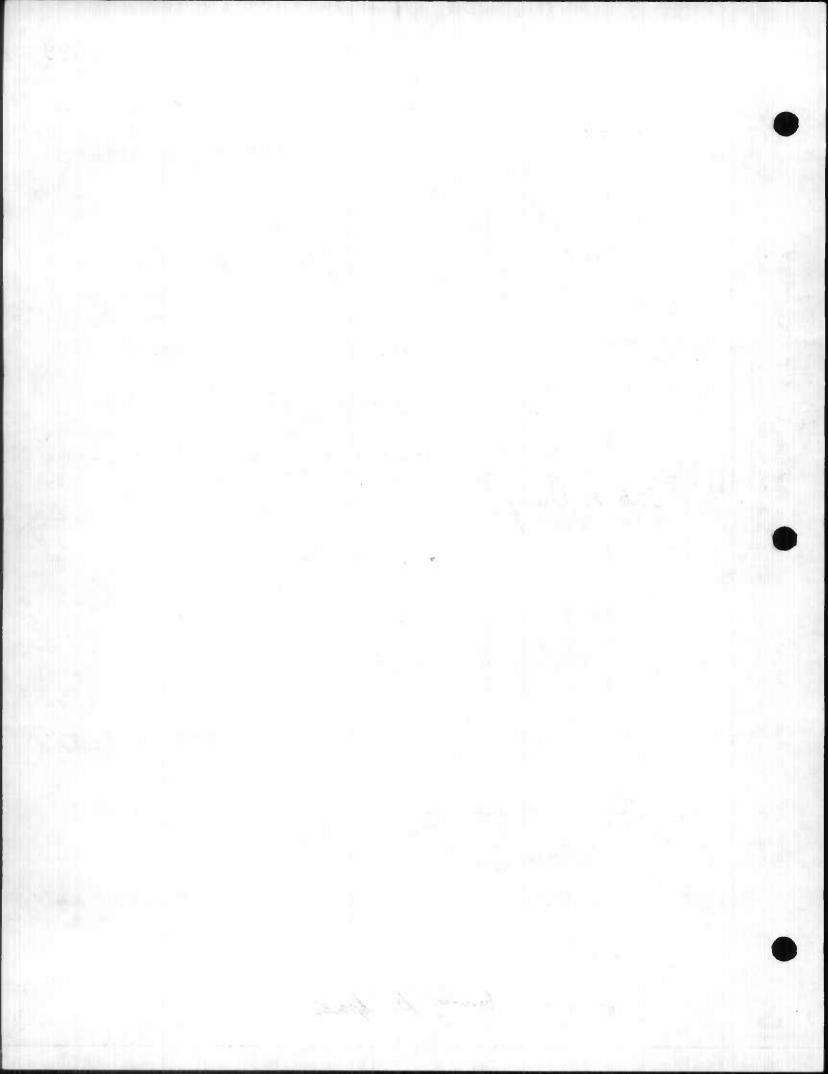
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09700 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** PAUL **LEONARD** LAYFIELD 1042 4b. City, Town, or Location of Death 4c. County of Death 10 2000 /Medical 4e Facility Name (If not institution, give street and number) Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) June 14,1910 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 12 M 2□ F 214-10-8963 89 Director Usual Residence of Decedent 10e. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Wicomico Delmar 1 ☐ Yes 2 2 No Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 31734 Melsons Rd 21875 IISA Funeral or Nems 11 Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2X No Specify: à Specify. 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland 21 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nert of Health and Mental Item 27 is marked Clayton James Layfield Mary Elizabeth Lecates 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Wheeler/Daughter 9405 Rumridge Rd., Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removel from Stete Important: Il any Injury o DDG 2/16/00 Melsons Cemetery Delmar, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Preumana disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner CHF The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, ASCUD Physician/Medical Due to (or as a consequence of): 88 Demenhin 080 signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes en autopsy performed? completion of cause of death? page 2 1 1 Yes 2 No certificata 1 Yes Division of Vital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation 1 Matural after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide filled in 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical teh (Check only one) within 2 \$ 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 347094 NAGAN 2/11/00 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 2+5 SALISBURY MD 21804 106 SMHE 50KB MILFORD STIGET Bel NATESAW MI

DHMH 16 Rev 6/95

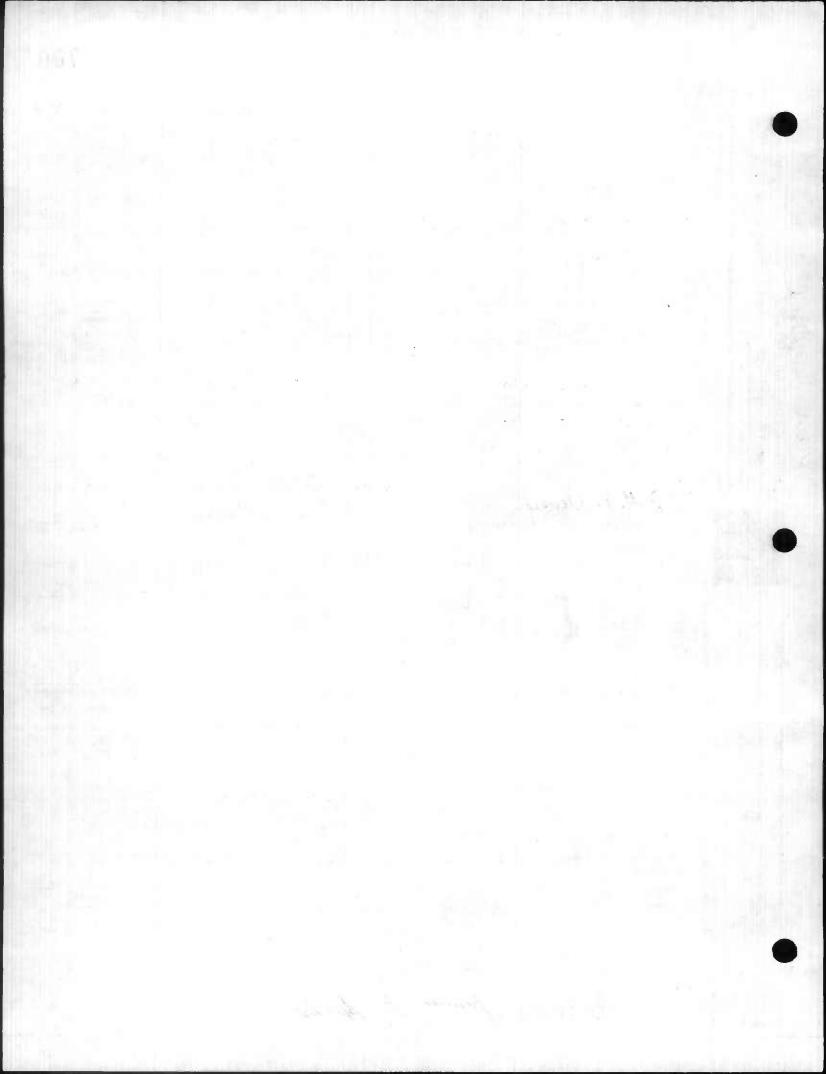
State

Registrar

31. Date filed (Month, Day, Year)

FEB 1 5 2000

32. Registar's Signature



4a Facility Name (If not institution, give street and number)

M.

BERLIN NURSING & REHABILITATION CENTER

1. Decedent's Nama (First, Middle, Last)

MAYRETTA

5. Social Security Number

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Months Days

LYNCH

7. Age (In yrs. last birthday)

Certificate of Death Reg. No.

If Under 24 Hrs.

Hours

4b. City, Town, or Location of Death

		/Medi Exami	
		Funeral Director	
manual factoria	21215-0020	d within 72 hours after death with the Maryland giene. It than "natural", or herrs 23e or 23e-1 show the Medical Examiner must be notified at	Completed by Funeral Director

Com

Physician /Medical Examiner

Baltimore, Maryland

that the death certificate be executed physician and is the burial-trans Box 68760. P.O. Records, Division of Vital

1□M 2 F 90 221-18-3754 APRIL 6, 1909 Usuai Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RT. 2 LOT 19 LANTERN LANE 19975 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tile. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiers Important: if them 27 is marked other than in any Injury or other traumette. College (1-4or 5+) Elementary/Secondary (0-12) **FARMER** 11 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALVIN MARY N. LYNCH Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY E. DAVIS/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LYNCH CEMETERY 2/16/00 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heef failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last tenuscherosis Physician/Medical Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 14/0 Acule Pulminnny Eden 1 Yea 2 No 3 Probably 4 Unknown þ 13-16 Blied Presure. 24a. Was an autopsy performed? Completed 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ceruman 29c. License number D02026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. FEDERICO ARTHES, M.D. 46 TEAL CIRCLE, BERLIN, MD. 31. Date filed (Month EB 16 2000

2000 7:00 P.M. 4c. County of Death WORCESTER Birthplace (State or Foreign Country) DELAWARE 10d. Inside City Limits 1 ☐ Yes 2 No

14. Race - American Indian. Black, White, etc.

> WHITE 16b. Kind of Business/Industry

POULTRY

JARMAN

2. Date of Death FEBRUARY 12,

8. Date of Birth (Month, Day, Year)

RD 1 BOX 61A, SELBYVILLE, DELAWARE 19975 20c. Location - City or Town, State

BAYARD, DELAWARE

HASTINGS FUNERAL HOME, SELBYVILLE, DE.

Approximate Interval Between Onset and Death

23b. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of causa of death?

2 No

1 ☐ Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

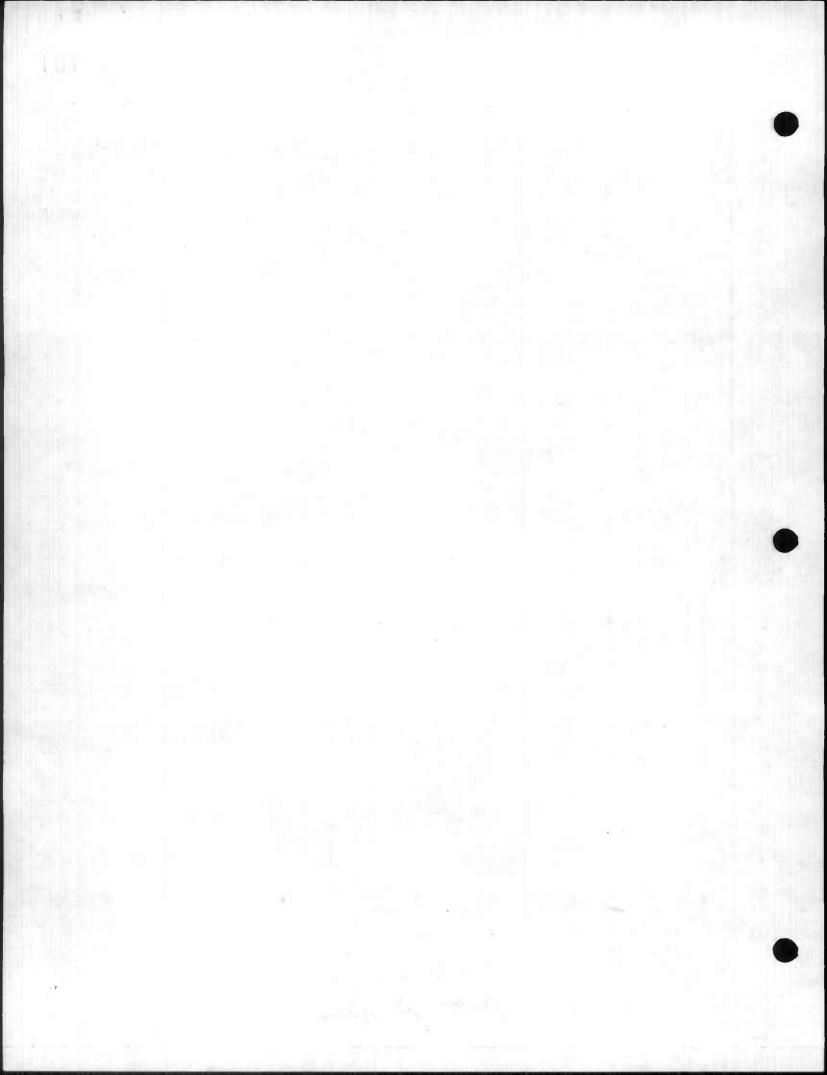
281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

12-2000

21811 410-641-4400

State Registrar



Division death. DIOTA after death To the Hospital within 24 hours a To the Funeral L completaly

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Baltimore, Maryland

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LAMBERT

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certificate be executed

P.O.

Records,

of Vital

State Registrar

Chris Snyde Aa. 106 mil Ford St. Suite Za, Sadio bury Md. 2/801

31. Date Hed (Month, Day, Year)

FEB 2 9 2000 32. Redsyars Signature G. Sporks

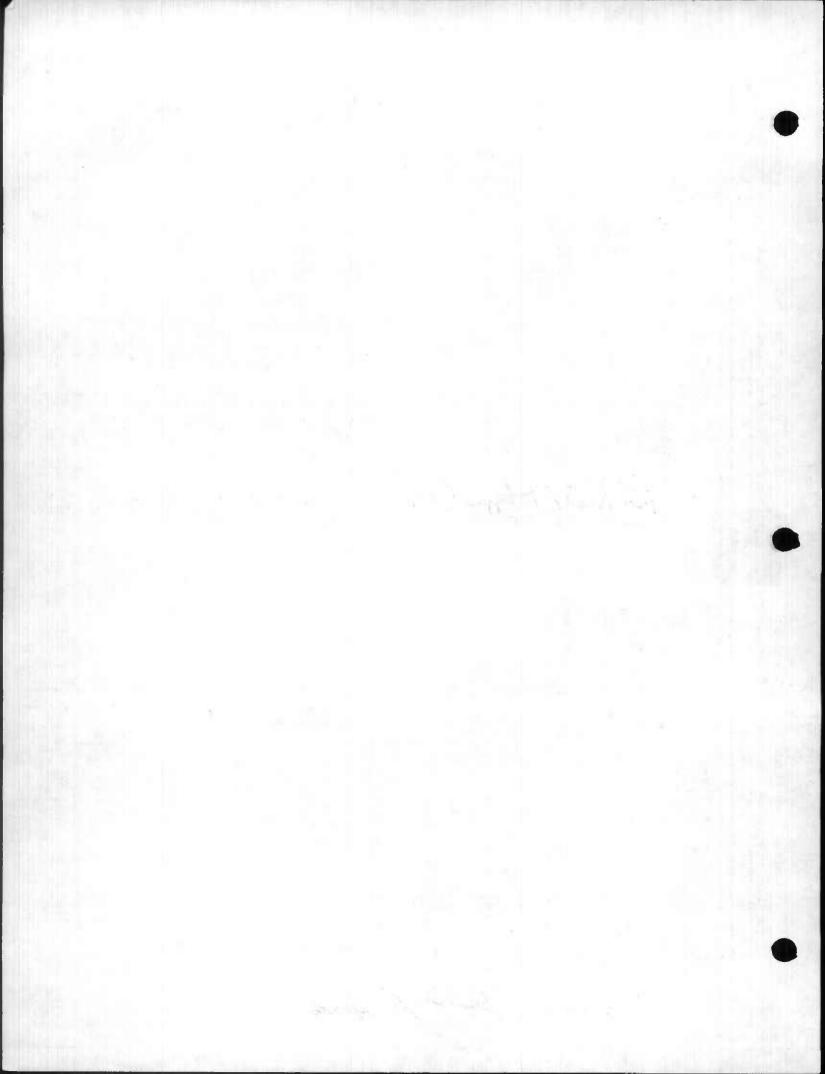
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title (N certified

29c. License number

29d. Date signed (Month, Day, Year)

2/28/00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

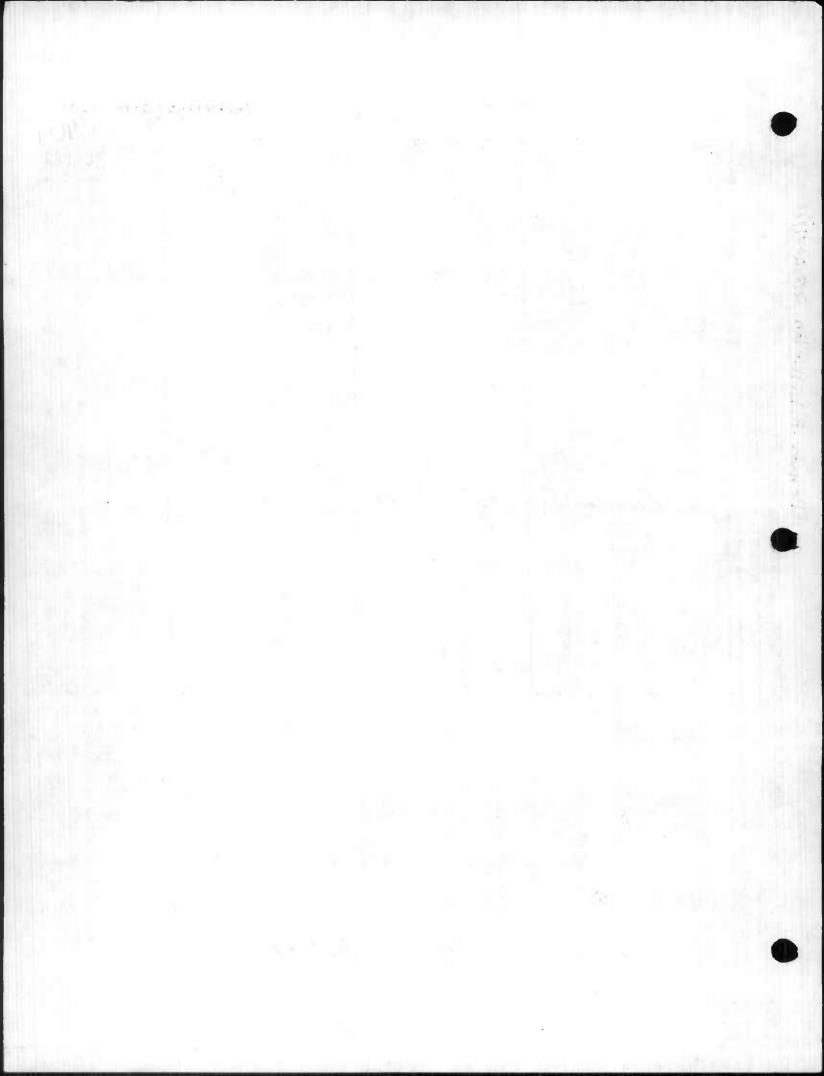
State of Maryland / Department of Health and Mental Hygiene

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5		1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) NEW HOPE CEMETERY 3/3/00 WILLARDS, M.												
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DHMH 16 Rav 6/95

G. Sparker



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death FEBRUARY 29 2000 Philip 14:07 LONG Arnold 4b. City, Town, or Location of Death 4a Facility Nama (II not institution, give street and number) 4c. County of Death BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) Data of Birth (Month, Day, Year) Months Days 51 218-48-8159 april 9,1948 Maryland Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1031 Riverside Dr. 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Morital Status Black, White, atc 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 ☐ Nevar Married 2 ☑ Married 1 Yas 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) 12 Broker Food 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Frank Long Anna Littleton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara D. Long/Wife 1031 Riverside Dr., Salisbury, MD 21801 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Parsons Cemetery 3/3/00 Salisbury, Md 22. Nema and Addrass of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Sarvice Licensaa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in deeth) PANCREATIC ISLET CELL 04-01-99 Dua to (or es a consequence of):

Physician /Medical Examiner

sician and burial-transit

Division of Vital Records, P.O. Box 68760,

Physician

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10a. Stata

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Pages 1 and 2 should be filed within 72 hours ather rand of Health and Medial Heylone.

Int. if them 37 is marked other than "netural; or its any or other traumetic event, the Medical Examples.

Baltimore, Maryland 21215-0020

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cause. Enter Underlying Cause (Diseasa or Injury that initiated avents rasulting in death) Last	CDua to (or as a consequence of):			
	d				
Part II. Other significant conditions of	ontributing to death but not re	sulting in tha undarlying cau	se given in Part I.	23b. Did tobecco use co 1 ☐ Yes 2 ☑ No	ontribute to the cause of death
				24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
		No.		1□ Yes 20 No	1 ☐ Yas 2 ☐ No
25. Wes case rafarred to medical examinar?				eath (Check only one)	
1 ☐ Yas → No	Hospital: 1 Inpatiant 2	ER/Outpatient 3 DOA	Other: 4 Nursing	Homa 5 ☐ Residence 8 ☐Ott	har (Specify)
27. Mannar of Death 1 Natural 5 Pending 2 Accidant invastigation		28b. Tima of Injury M	Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred
3 Suicide 6 Could not be datarmined	28e. Place of Injury - At I building, etc. (Speci	nome, ferm, street, factory, c	ffice	28f. Location (Street and Num. City or Town, State)	ber or Rural Route Number,
				ce, and due to the cause(s) and m curred at the time, date and place,	
29b. Signeture end title of certifier		29c. l	icense number	29d. Data signe	ed (Month, Day, Year)
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DHMH 16 Rev 6/95

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State

Registrar

within 24 hours after death.
To the Funeral Director: A completely filled in by the fi To the Hospital of within 24 hours a To the Funeral D

Physiciens
32. Registrar's Signatura

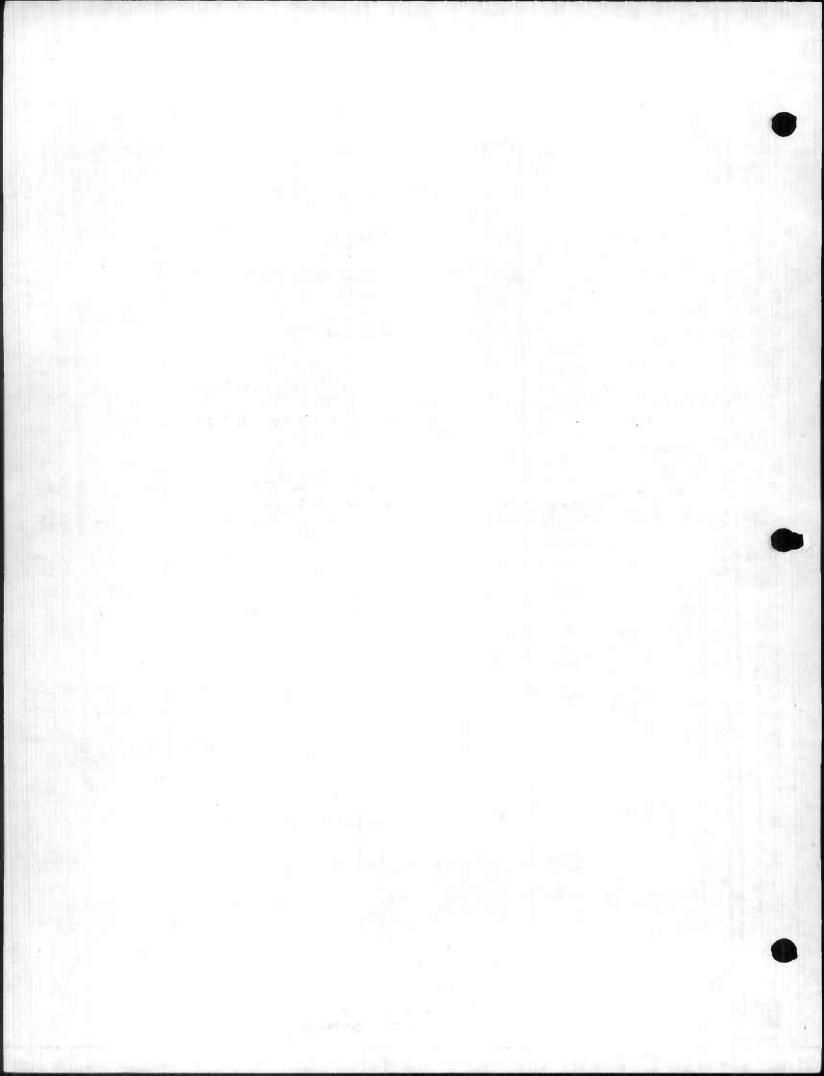
Lounge Tower Building Johns Hopkins Hospitil

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

McWilliams

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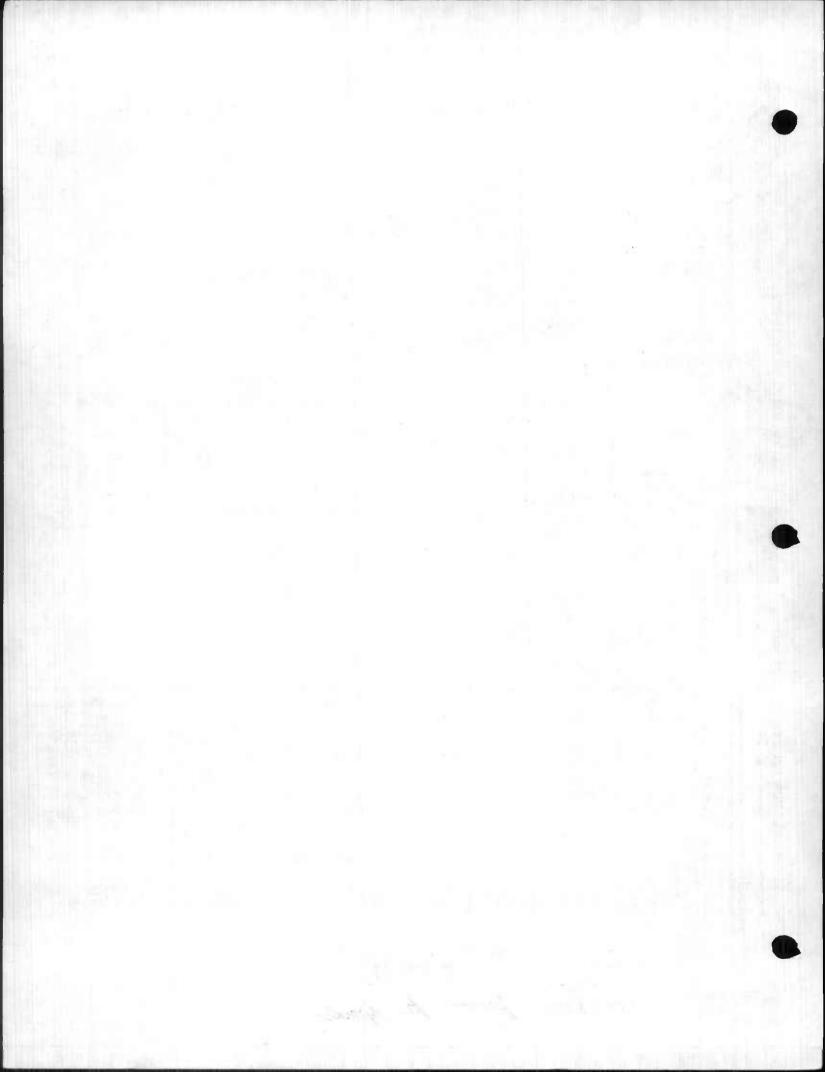
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State of Maryland / Department of Health and Mental Hygiene 00 09705

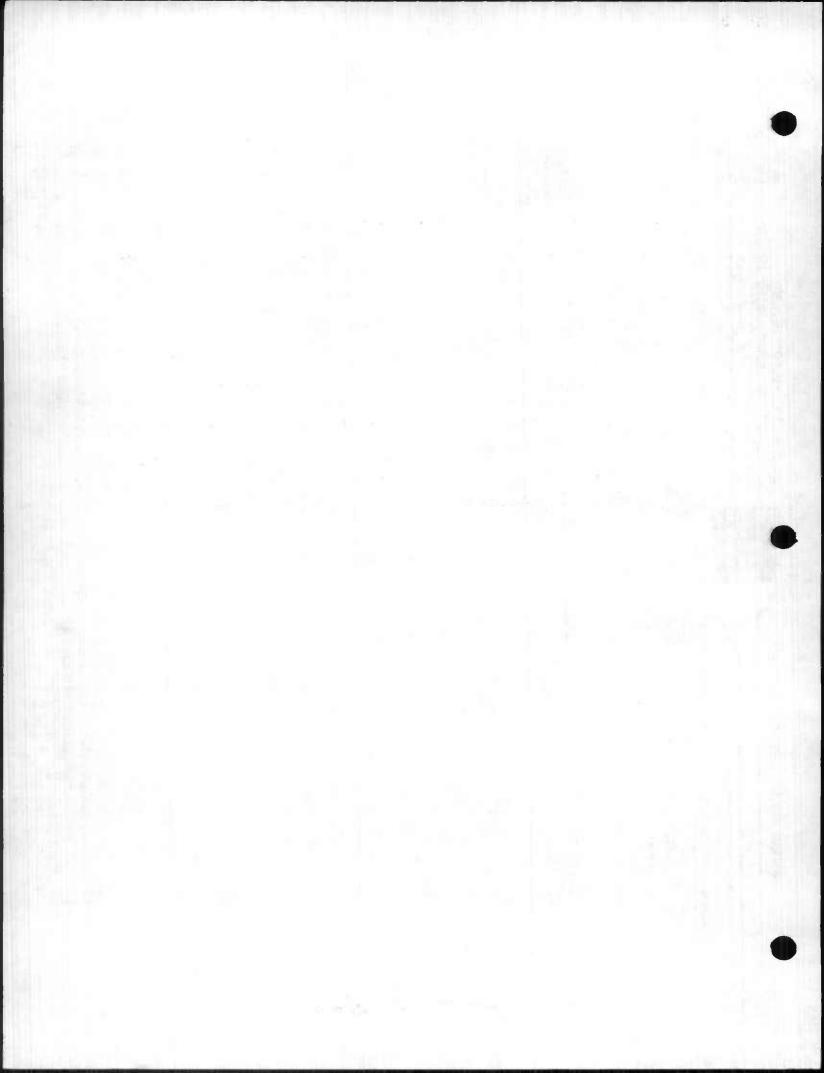
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Physician	LEE		Februa	bay ary 21,2	Year	110)5				
/Medical Examiner	4a Facility Name (If not institution, gr	ve street and number)				4b. City, Town, o	r Location of Dea		y of Death	1 2 4 0	15
Adminici	504 South Divis	sion St				Caliaby	1207 7	1.1.2			
		Sex 7. Ag	Salisbu			COMIC 9 Birtho		e or Foreion			
neral ector		1. M 2 F	54 Y	s Deys	Hours Mir	Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Country) September 26, 1945 Pennsylvan					
	Usual Residence of Decedent						Беросия	CL DO/131	7 14	TE YEV	A LICA
	10a. State 10b. County		10c. City, Town	or Location					1	10d. Inside	City Limits
0	Maryland Wicomi	ico	Sal	isbury	7		1 2 Yes 2 □				
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era era		2100				(Casait, Van er N		ce - Americ	non Indian		
Funeral	11. Marital Status	Armed Forces? If Yes, specify			pecify Cul	ben, Mexican, Pue	erto Rican, etc.)	Bla	ck, White,		
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	3 Widowed 4 Divorced		Coast Guard								
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mportant my injury 2028	4 Donation 5 Other (Special	tery	2/28/00 Hurlock, MD								
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a	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804										
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o Be	examiner?	Hospital:			0	ther:	eeth (Check only			-	
-	1 Yes 2 No	1 L inpatie			DOA	4 LI Nursing	Home 5 Res			(y)	
- Lo	27. Manner of Death 1 ⊠Naturel 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Tin	ury	28c. Inju		280. Describe	how injury occu	med		
cati	2 Accident investigation			М	1	Yes 2□No					
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edical		hysician: To the best									-/->
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	20 Novem 66	7.	mQ (
	30. Name and address of person who) OIII	DEEM #203	CALT	י עמומי	י זער א	IND 2	1904
4	JOHN T. BULKELE			ITLEOKI) SIF	REET #201	DALI:	SBURY, M	HKILA	רא תוא	1004
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State of Maryland / Department of Health and Mental Hygiene

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Examiner		(If not institution, givery Center;			rCare			Salis	sbury		4c. County Wicom		
Funeral Director	5. Social Security 147-07-	1905	ex CM 2□F	7. Age (In yrs. 94	last birthday) Yrs.	If Unde Months	Deys	Hours	Min.	Dete of Birth (Month, Day)	Year) 1905	Count	ace (State or Fo ry) arolin
Di a	Usual Residence	of Decedent 10b. County		10c. Ci	ty. Town or Lo	ocation						10	d. Inside City L
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inter death with the ma the rough or 28s-1s the rough or current funeral Director	10e. Street and N	-	-0		Tyc	10f. Zi	p Code			1	Og. Citizen of \	What Count	ry?
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Department of Heel Important: If Item any injury or othe page.	20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City										City or To	wn, State	
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	21. Signature of F	uneral Service Licer	Moo-		22	Name e	nd Addre	ss of Facility	2221	Homo	P.O.	Post	61
	N in	him 2	100	il				, Md			, P.O.	BOX	91
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s certific director,	examiner?	No	Hospitel:		ER/Outpatie	nt 3 D	Oth		0	Check only or		/04	4
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	-	de	0	un			1	3/5	2/5		-1-	-1/	
1	30. Name and edd	Iress of person who											
)	1104 HEALTHWAY DR., SALISBURY, Md. 21804 Tate 31. Dete filed (Month, Day, Year) 32. Register's Signature G. Long L.												
State Registrar	31. Dete tiled (Mo	FEB 22 2	000 32. Re	glever's Sign	A S	. 1	oous	41					
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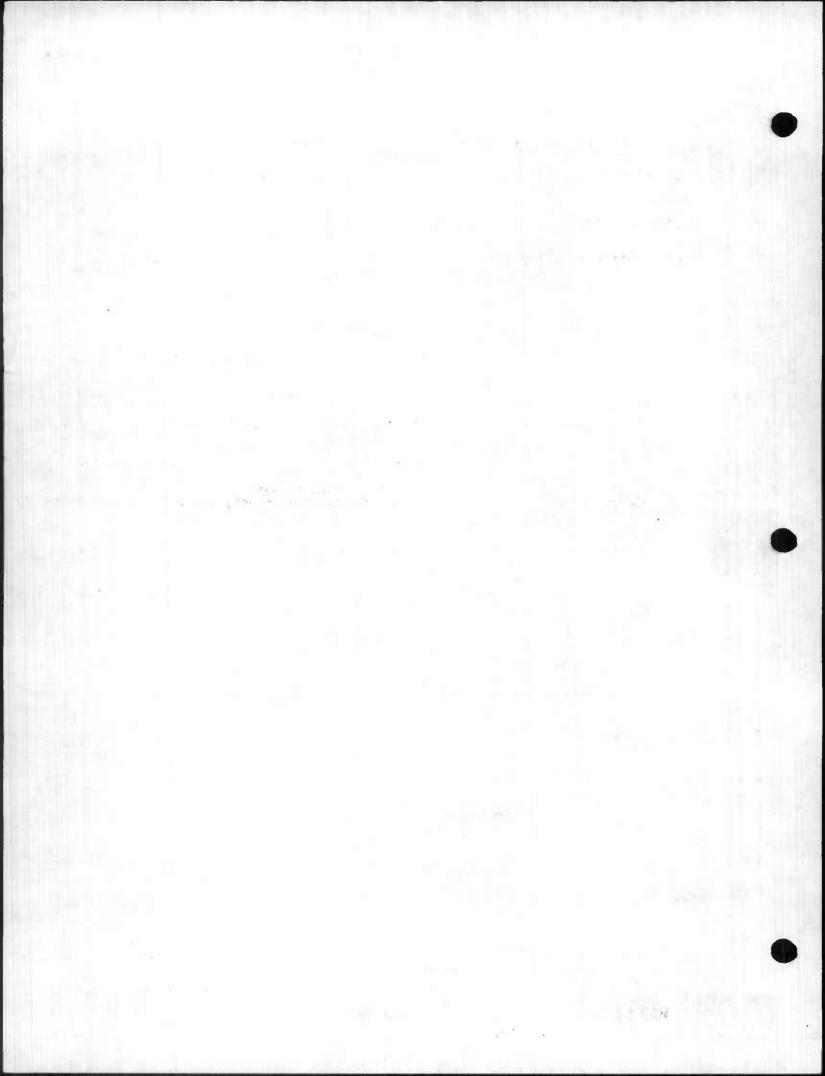


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** March 10, 2000 Harry Edward Logan 19:02 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County **Elkton** Ceci1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 10 M 2□ F Days Director 218-01-7209 September 16,1914 Maryland Usual Residence of Deceden 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No Director 288-1 Maryland Cecil North East 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or harns 23s or must be Funeral 811 Mechanics Valley Road 21901 United States 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 XYes 2 No If Yes, Give 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced ratural. Year or Dates White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Builder 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surnama) 12 should be fill h and Mental H I is marked off Be 10 Clarence Logan Dora Goodnow 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if Item 27 is any injury or other tra-otics. 811 Mechanics Valley Road, North East, Maryland 21901 Dorothy E. Logan / Spouse 20b. Place of Disposition (Neme of cematery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State March 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 15,2000 Elkton, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Crouch Funeral Home 127 South Main Street, North East, Maryland 2190 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. O'am Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Examine Cardreny dilated eass be axecuted and Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): physician a Box 68760 Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of) for use es 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. the 2 1 Yes 2 No 3 Probably 4 Unknown be det Records, P 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 HO 1☐Inpatient 2☐ER/Outpatient 3☐ DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 BNatural 5 Pending To the Hospital or Attendit within 24 hours after deeth.

To the Funeral Director: At completely filled in by the fu 1 Tyes 2 No deeth. Investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Medical ★☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifige 29c. License number 29d. Date signed (Month, Day, Year) 4410 mil un 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William F. Renzulli, 901 Warburton Road, Elkton, Maryland 21921 31. Date filed (Month, Day, Year)
MAR 13 2000 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death March fy, 2000 Louisa Popham Leonard 4:45 PM 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Dorchester General Hospital Cambridge
If Undar 1 Yaar If Undar 24 Hrs. 8. Data
Months Days Hours Min. (Mont Dorchester 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 200 Days Yrs. 433-68-2628 Usuel Residance of Dacedant 90 Dec 19,1909 Canada 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Cambridge Dorchester 10e. Street and Number 10f. Zip Coda 10n, Citizan of What Country? 5400 Morris Neck Road 21613 12. Was Decedanf Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - American Indian, Black, White, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☐ No If Yas, Give X Yaar or Datas: 1 ☐ Yas % No Specify White 3 Widowed 4 □ Divorced 15. Decadant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifta. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11 4 Nurse State Government 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Guy H. Popham Louisa Glover 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Jim J. Popham 5400 Morris Neck Road Cambridge, Maryland 21613 Nephew 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donatjon 5 ☐ Other (Specify) 3/15/00 Wortham Cemetery Wortham, Texas 21. Signature of Funaral Service Licensea 22. Nama and Addrass of Facility Thomas Funeral Home, P.A. 23a. Part. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiretory arrest, approximate Interval Batween Onset and Death Immediate Cause (Final · Cardiac Arres disaesa or condition rasulting in death) SMIN entucular Saquanfielly list conditions, if any, leading to immadiata ceusa. Entar Undarlying Cause (Disease or Injury finat initiated avants rasulting in daath) Last oronary Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death?

Physician /Medicai Examiner

The law requires that the death certificate be axecuted

Box 68760.

Records, P.O.

Division of Vital or Attending Physician: **Physician**

/Medicai

Examiner

Director

by Funeral

Completed

Be

Funeral

Director

in and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinat must be notified at

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be 1 nent of Health and Mental I

item 27 is other tra

= 8 Depertment of important: If any injury or

> Examiner Physician/Medical þ Completed Be Certification: To

for use as

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this funeral

After

s after death.

24 hours a Funeral L Hospital

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Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. Jementa

1 | Yes 2 348 3 ☐ Probabiy 4 ☐ Unknown

24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy parformed?

1 ☐ Yas Q☐ No

25. Was cesa rafarrad to medicel examinar?

26. Placa of Death (Check only one)

Othar: 4 Nursing Home 5 Residence 6 Othar (Specify)

1 Yas 2000 27. Mannar of Death 1 Ratural

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of NIA

28c. Injury af Work? 1 Yas 2 No 28d. Describe how Injury occurred MIA

5 Panding Invastigation 2 Accidant 6 Could not be datarminad 3 Suicida 4 Homicide

MAR 13 2000

28a. Place of Injury - At home, farm, streat, factory, offica building, atc. (Spacify)

NIA

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

Cambridge MD 21613

29a. Cartifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, daeth occurred af the time, deta and place, end due to the ceuse(s) end menner es stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred af the time, data and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

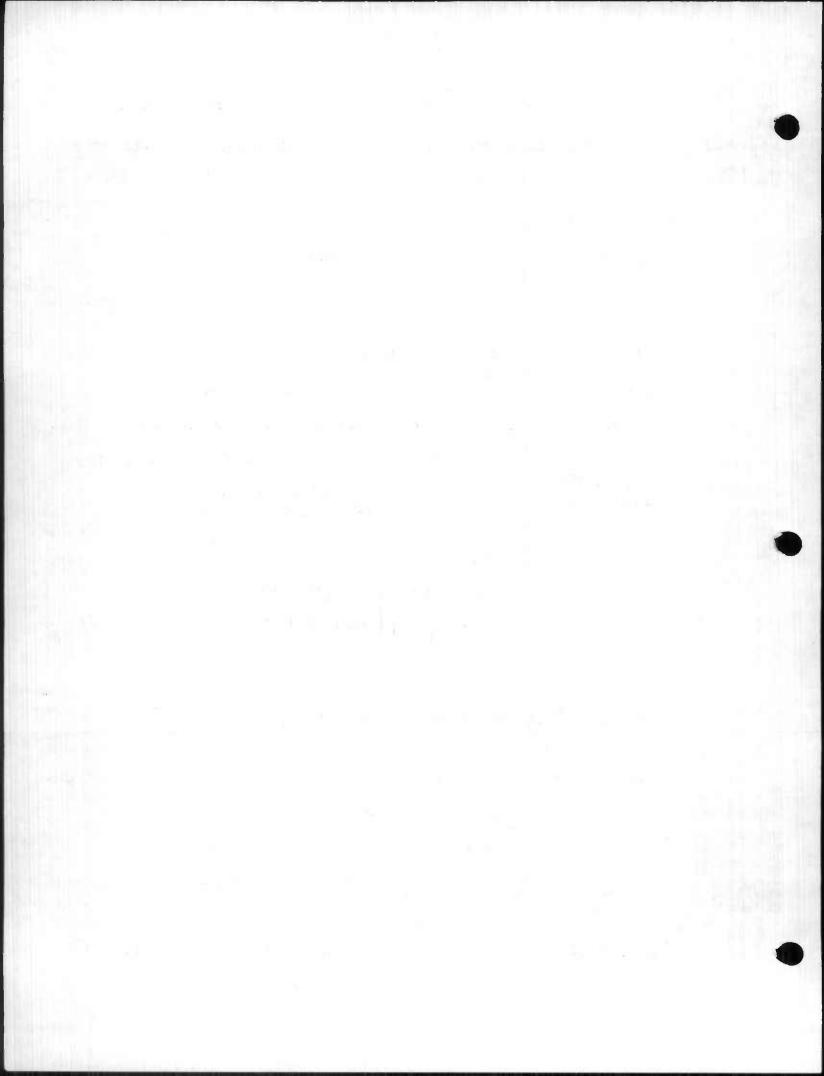
29b. Signafura and titla of certifiar ulhi 29c. Licansa number 284

30. Nama and addrass of person who complated cause of deeth (Item 23e) (Type, Print)

AR WILKE 31. Data filed (Month, Day, Yaar)

100 Maryland 32. Registrar's Signeture

State Registrar



State Registrar

MISHYSRUTS

and eddress of person who completed cause of death (Item 23a) (Type, Print)

2000

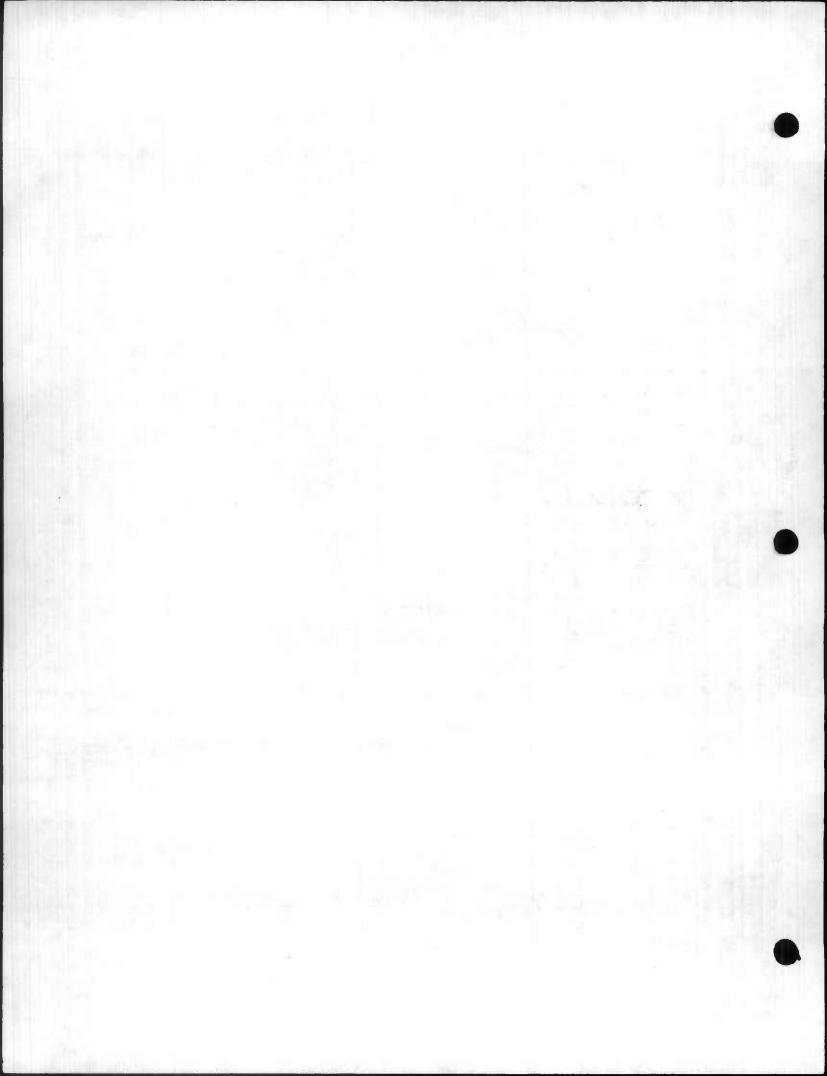
Korou

32. Registrar's Signature

O.C.M.E.

W 111 Penn Street, Baltimore, Maryland 21201

March 8, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9710.

			Cer	TITICATE OF	Death		Reg. No.				
ysician	Decedent's Nama (First, Middle, Las					2. Date of De Month	Day Day	Yaar	3. Time of Death		
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aminer	4a Facility Name (If not institution, give	the state of the state of			4b. City, Town, or						
eral	4905 Muskogee S 5. Social Security Number 6. Sa		last hirthday	If Under 1 Year	College		Princ		orge's		
		M 2□F 68	Yrs.	Months Days	Hours Min		Y Year)	Country	ce (Stete or Foreig r) rgia		
	Usual Residence of Decedent	00				THAT CIT I	0, 1)31	000	1614		
	10a. State 10b. County	10c. Cit	ly, Town or Lo	cation		21.00		100	d. Inside City Limit		
tor	Maryland Prince (George's Co	llege	Park					1X Yes 2 □ N		
Directo	10e. Street and Number	corge 5 Oc	TICEC	10f. Zip Code			10g. Citizen of W	/hat Country	17		
	4905 Muskogee S	Street		207	40	977	U.S.A.				
Funeral	11. Marital Status	12. Was Decedent Ever in U	,S. 13. V	Was Decedent of I	lispanic Origin? (Specify Yas or No)- 14. Race	a - American			
2	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 1 Yes 2 □ No 194 If Yes, Give	Q_	Tes, specify Cub	an, Mexican, Puèr	no moan, atc.)	100	k, Whita, etc	G.		
2	3 ☐ Widowed 4 ☐ Divorced	Year or Detas: 19		183 252110	эрвону.		Specify:	W	hite		
200	15. Decedent's Ed (Specify only highest grad	ucation le completed)	16a. Deced	dent's Usuel Occup	pation during most of wo	orkina	16b. Kind of Bu	siness/Indu	stry		
Completed	Elementary/Secondary (0-12)	College (1-4or 5+) life. DO NOT use retired)									
		1	Senior	Master Sa	rgeant Par		U.S. A:		ce		
9	17. Fathar's Nama (First, Middla, Last)						, Maiden Sumem	a)			
0	Unavailable				Velma						
	19a. Informant's Name/Relationship (T				end Number or A						
	Pearl M. Leopard -				Street,						
	20a. Method of Disposition 1 🖾 Burial 2 🗆 Cramation 3 🗆 I	Removat from State	Ptace of Dispos cematary, cran	sition (Neme of netory or other pla	ce)	3/14/2000	20c. Location -	City or Town	n, State		
	4 □ Donation 5 □ Other (Specify	Ar	lingto	n Nationa	1 Cemeter	y 11,2000	Arlingt	on, V	irginia		
	21. Signature of Funerat Service Licens	see .	22	Name and Addre	ess of Facility neral Ho	ma D A					
1111	(landott	e 2. Das			more Ave			. MD	20781		
	23a. Part1. Enter the disease, or comp shock, or heert failure. List only of	lications that caused the daat						. A	Approximate nterval Between		
/sician								C	Onset and Death		
	Immediate Cause (Final disease or condition and commany artifug during a section of the condition and condition an										
	resulting in death)	disease or condition resulting in death) Due to (or as a consequence of):									
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	Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Ceuse (Disease or injury										
edicai	that initiated events resulting in death) Last	Dua to (c	or as a conseq	uance of):							
Me		d									
Physiciar	Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cause gi	ven in Part t.	23b. Did	tobacco usa cor	itribute to t	the cause of deat		
	Henrifu	mulita				1 🗆	Yes 2 No	3 Probe	ibly 4 Unkno		
l by		7	-13		1-11	040 11/04		24h Wer	e autopsy findings		
Completed						part	s an autopsy ormed?	avail	table prior to pletion of causa		
ğ								of de	eath?		
3						1 🗆	Yes 2 No	10	Yas 2□ No		
	25. Was case referred to medical examiner?	11-2 5-1		100		eath (Check only	one)	-			
2	1 Tes 2DNo		ER/Outpatien	I 3L DOA	her: 4 Nursing	1	idence 6 Othe				
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-	2 Accident investigation 3 Suicide 6 Could not be			M 1]Yas 2□No						
21111	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory, office			(Street and Numb wn, State)	er or Hural i	Houte Number,		
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COLCAL	(Check only 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina									
	one)	and manner stated.		200 dicon	ee number		29d. Data signad	d (Month D	ev Veerl		
Σ	29b. Signature and lifte of certifier	1()	1 -	29c. Licen	A () T						
	1000	le ay	(m)	2	0 7 3 9 5	5	March 8	, 200	U		
1	30. Name and address of parson who c										
1	Charles Taylor, M.			rive, Co	lumbia,	Maryland	21045				
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State of Maryland / Department of Health and Mental Hygiene 0 0 9 7

1000	Decedent's Nama (First, Middla, Las	1)	C	ertificate of	Death	2. Data of De	Reg. No.	3. Time of Deal	
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	5. Social Sacurity Number 6. Se		irt E. Ja (In yrs. last birthda	v) if Undar 1 Yaa	Larg	10	Princ	ce Georges	
Funeral Director		M 2□ F	64 Yrs.	Months Days	Hours Mir	s. 8. Data of Bi (Month, Di Nov. 3	, 1935	9. Birthplaca (Stata or For Country) Pricedale, P	
Mo ti	10a. Stata 10b. County		10c. City, Town or	Location				10d. Inside City Lin	
ctor	Md. Prince	Georges	Larg	go				1 ∑ Yas 2 □	
r items 23e or 28e-f show instrings be notified at Funeral Director	10e. Street and Number 640 Mt.Lubenti	a Court	Ε.	10f. Zip Coda 2 0	774		10g. Citizan of V	What Country?	
ğ	11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forcas? tyll Yas 2 I If Yas, Giva Yaar or Datas:	Evar in U,S. 13	3. Was Decedant of if Yas, specify Cul 1 ☐ Yas 2 ☐ No		Specify Yas or Norto Rican, atc.)		e - Amarican Indian, ck, Whita, atc.	
a hygiena. d other than "naturn event, the Medical by Completed	15. Decedant's Edi (Specify only highast grad	ucation fa completed)	16a. Dec	pedant's Usual Occu	ipetion	ndeina	16b. Kind ot Bu	usiness/Industry	
mple	Elementery/Secondary (0-12)	Collega (1-4or	5+)	va kind of work done DO NOT usa retin		JANINY .	Gov.		
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Arked of attic eve	Matthew	Lemon			TO. INIOCITAL STATE	Georgi		iggs	
mari mari	19e. Intorment's Name/Relationship (T		19b, Ma	lling Addrass (Stree	nt and Number or F				
27 is 27 is or tra	Eleanor Chilto	n-Lemon					-	4d. 20774	
t: If Item y or oth	20e. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ I 4 □ Donation 5 □ Other (Specify,			position (Nama of rematory or other plain ill Cemet	-	Data		City or Town, Stata	
Important: If in any injury or once.	21. Signature of Funarai Sarvice Licens			22. Nama and Addr		3/13/00 Hunt Fu		nd, Maryland	
Department Important: II any injury o	Arancio B. 3	ant	CC0353	908 Kenn	edy St.	N.W.Wa	sh.D.C		
ysician Medical saminer	23a. Part1. Enter the disease, or comp shock, or haert tailura. List only o Immediata Cause (Finel disease or condition resulting in death)			Lung Car		ec or raspiratory a	irrest,	Approximata Interval Between Onsat and Death	
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physician and s the burlet-transit dical Examiner	Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaasa or Injury	b	Dua to (or as a cons	equence of):					
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ed by the attending deteched for use	Part II. Other eignificant conditions co	ntributing to death b	ut not resulting in tha	undariying causa g	iven in Par(i.		Yee 20 No	atribute to the cause of dec 3 Probably 4 Unkn	
been signe should be d						24a. Was	an autopsy ormed?	24b. Ware autopsy finding available prior to completion of cause of death?	
page 2						10	Yes 2XINo	1 ☐ Yae 2 ☐ No	
rector, pag	25. Was casa rafarred to medical				26. Place of De	eath (Check only			
this aldi	examinar? 1 Yas 2 No 27. Menner of Death 1 Netural 5 Panding 2 Accident invastigation	1 Inpatie 28a. Dete of Inju (Month, De		of 28c. Inju		Homa 5 Ras 28d. Describe	dence 6 Oth		
within 24 hours effer death. To the Funeral Director: Affer to completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not be detarmined	28a. Place of Inj building, at	ury - At homa, farm, s c. (Specify)	streat, factory, office		28t. Location (City or To		er or Rural Routa Number,	
othe Funeral Dir completely filled in Medical Cert	29a. Cartifiar (Check only one) 1 ☑ Certifying Phy 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner ste	of my knowledge, das axamination and/or	ath occurred at tha t invastigation, in my	ime, date end plec opinion, death occ	e, and due to tha urred at tha time,	causa(s) end ma data and place,	innar as stated. and dua to tha cause(s)	
To th	29b. Signature and title of certifier	forda	un	29c. Lican	sa number	MARRY AND	29d. Datâ signe	(Month, Day, Yaar)	
20/	30. Nama and address of person who co	en en o	eath (Itam 23a) (Typ	A Print) Kev	IN ME	ROM	5		
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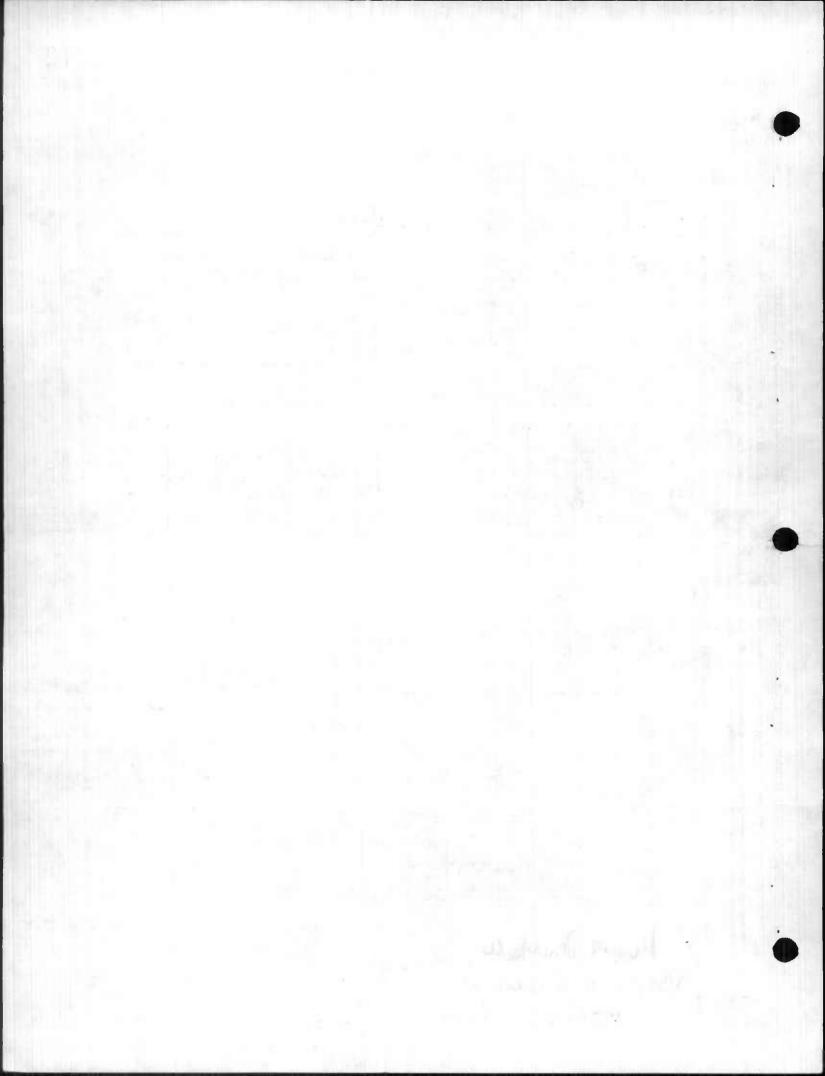
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

rsician	#23 PART I	lle, Last)							2. Date of Month MARC	Death Day	746	3. Time of Deal
niner 4a Facili	ty Name (If not institution HINGTON COU	on, give street and				4	tb. City, To		ocation of De	4c. County of Death WASHINGTON		
224-	Security Number	6. Sex 12 M 2	7. Age (In yrs. 37	last birthday) Yrs.	If Under 1 Months C	Year Days	If Under Hours	Min.	8. Date of (Month,	Day, Year)	9. 2 V:	Birthplace (State or For Country) irginia
Usuel Re 10a. Stat W. V 10a. Stre				y, Town or Local							10d. Inside City Lin	
17 11. Merite	et and Number			leugesvi	10f. Zip Co				10g. Citizen of What C			t Country?
11. Merite	Morgan Vil: el Stetus lever Married 2 \ Ma Vidowed 4 □ Divorce	12. Wes D Armed 1 1 Yes	Decedent Ever in U Forces? es 2 🕅 No Give or Dates:	25427 J.S. 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:					U.S.A. pecify Yes or No- p Rican, etc.) 14. Race - Arre Black, Whit			American Indian, White, etc. White
	15. Decede (Specify only highe ntary/Secondary (0-12) 12	(Give k	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ceiling Mechanic					Aco	ustic lings			
17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Donald Luther Lewis Betty Lou Mundy 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State								(te, Zip Code)				
Maria E. Lewis - Wife 17 Morgan Village Hedgesville, W. Va. 25427 20e. Method of Disposition 1 Determine State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cernetary or other place) Greenlawn Memorial Park 3/18/00 Williamsport, Maria 1. Signature of Funeral Service Licensee 20b. Place of Disposition (Name of cernetary or other place) 3 Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland											y or Town, Stata port, Maryl ome	
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25. Was case referred to medical axaminer? **DXYes 2 \(\text{No} \) Hospitel: XX Inpatient 2 \(\text{ER/Outpatient} \) 3\(\text{DOA} \) 26. Place of Deeth (Check only one) 27. Manner of Death 1 \(\text{Nursing Home} \) 5 \(\text{Pending} \) Pending (Month, Day Year) 28. Date of Injury at Work? FOUND; M 1 \(\text{Ves} \) 28d. Describe how injury occurred Work? FOUND; M 1 \(\text{Ves} \) 28d. Describe how injury occurred Work? FOUND; M 1 \(\text{Ves} \) 28d. Describe how injury occurred Work?									SELF 281. Locatio City or	esidence be how injur INFLI n (Street an Town, State	CTED od Number of MO	WOUND or Rural Route Number, PRGAN VILLAC
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James Merle Martin March 1, 2000 12:30 A.M. /Medical 4a. Facility Name (If not Institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Millennium Health & Rehabilitation Center Edgewater Anne Arundel If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) If Undar 1 Yaar Months Days 6. Sex 1Å M 2□ F 5. Social Security Number 9. Birthplaca (Stata or Foraign Country) **Funerai** Days 178-07-2007 Director 82 Sept. 3, 1917 Pennsylvania Usual Residence of Decadent 10a. State rai', or itams 23a or 28a-f ahow Examiner must be notified at 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes XXNo Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1734 Chesapeake Drive 21037 USA Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1939–63 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2X Married Saltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced Completed traumatic evant, the Medical 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filled within nent of Health and Mantal Hyglene. nt: If Item 27 is marked other than iry or other traumatic evant, ira Ma Elementary/Secondery (0-12) College (1-4or 5+) 12th Senior Master Sgt. U.S. Military 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) William L. Martin Anna Laura Frank 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Streat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) L. Ruth Martin/ Wife 1734 Chesapeake Drive Edgewater, Maryland 21037 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1XXBurial 2 ☐ Cremation 3 ☐ Removal from Stata permit. Pege Depertment of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Lakemont Meml. Gardens 3-4-00 Davidsonville, MD 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final CARDIAC ARRHYTHMIA disease or condition resulting in deeth) Examiner more than Examiner CORONARY ARTERY DISEASE year the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last More than physician s the buriel Box 68760. ATHEROSCLEROSIS by Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown Vascular disease 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? COPD 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only ona) examiner? Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 4 Homloide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatura and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Yaar) D 50653 3-01-2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN CHAND SURAND

State Registrar

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31. Date filed (Month, Dey, Year)

Deale Churchton

ey, Year)

32 Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** 2000 12:50 AM March 6, Dorothy A. Mislicky /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Data of Birth (Month, Day, Year) Feb. 26, 1926 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 561-38-2877 Yrs. Feb. 74 Director Usual Residence of Decedent with the Maryland 10d. inside City Limits 10a. Stata 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 Yes 2 No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code Dir 1402 Cedar Park Road 21401 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Maritai Status permit. Pages 1 and 2 should be filed within 72 hours after loopertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or free any injury or other traumatic event, the Medical Event page. Black, White, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: PY 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be 0 Albert L. Anderson Myra Wayson 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Florence Barnes/ Sister 2 Williams Drive Annapolis, Md. 21401 206 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 【Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 03-07-00 Brentwood, Maryland sature of Funeral Service Licens 22. Nama and Addrass of Facility John M. Taylor Funeral Home, Inc. n 147 Duke of Gloucester Street Annapolis, Maryland 21401 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or completely shock, or haart feilure. List only one of Approximate intarval Between Onset and Death **Physician** ung cancer 2/2 445 /Medical Immediata Causa (Finai disease or condition rasulting in death) Examine Due to (or as a consequence of) Examine Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown emphusema bengis leb ed b Records, þ requires 24b. Wara autopsy findinga available prior to 24a. Was an autopsy performed? Completed completion of cause of death? The lew page 2 1 ☐ Yas 2 ☐ No Division of Vital Physician: 25. Wes case referred to medical axaminar? Be 26. Place of Deeth (Check only one) axaminar? To Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? After Naturai 2 Accident or Attending 5 Pending after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one)

State Registrar

31. Data filed (Month, Day, Year)

Selowell, wo

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 900 Bestgate Annapolis, Md. 2140) 32. Registrar'a Signatura

To the To To the F

29c. License number 019838

29d. Data signed (Month, Day, Year)

2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death February 25, 2000 **Physician** Paul Frederick McKenzie 6:57 pm /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel North Arundel Hospital If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) Feb 8, 1918 If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Months Hours 204-01-6253 1XM 20 F Yrs Pennsylvania **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show ms 23e or 28e-f short mast be notified at Arnold MD Anne Arundel 1 Yes 2 No Director 10f, Zip Code 21012 10g. Citizen of What Country? 10e. Street end Number USA 101 Howard Avenue Funeral Nems : Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status r than "natural", or iter filed within 72 hours after 1 ☐ Never Merried 2 ☑ Merried 1 Yes 1 No 21215-0020 White 1 ☐ Yes 2 ☒ No Specify: Specify P 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Golf Golf Professional 12 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be filmer of Health and Mental Hanne If Rem 27 is marked out Sarah Shields Hiram Small McKenzie 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 101 Howard Avenue, Arnold, MD 21012 Mary McKenzie/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlel 2 Cremetion 3 ☐ Removel from Stete Mar 1 Baltimore, MD Metro Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Funeral Service Lice 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD inc. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Applications that cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel VENTRICULAR 1:13 RILLATION MINVIES disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner MINUTES 816.CE 01 CHOKING OW MUNT or Attending Physician: The law requires that the death certificate be executed physician and the burial-frans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): 45 USB been signed by the atter should be detached for P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 20 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 No 1 Tes 1 ☐ Yes 2 ☐ No certificate Division of Vital director, 25. Wes case referred to medical 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? After 1 Neturel 5 Panding investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, sfreef, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signeture end title of certified 29d. Dete signed (Month, Day, Year) Church Mn 701865 26 5 0 ernd 30. Name and adoless of person who completed cause of death (Item 23a) (Type, Print) 8 EVERGREEN NOHO SEVENWA PARK mo 21146. GENARN CHUNCH

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State

Registrar

31. Date filed (Month, Dey, Year)

FEB 2 9 2000

32. Registrer's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	out of mary	Certificate of	f Death	Reg. No.						
Physician /Medical	1. Decedent's Name (First, Middle, Last)	Mars	2. Date of Month		3. Time of Death 4:35am					
Examiner	4a Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of E Annapolis	Death 4c. County of Death Anne An	h					
Funeral Director	5. Social Security Number 578-03-6932 Usual Residence of Decedent	yrs. last birthday) If Under 1 Ye 82 Yrs. Months Day	ar If Under 24 Hrs. 8. Date o ys Hours Min. (Month Jul	y 2, 1917 9. Birth Co y 2, 1917 Wasi	hplace (State or Foreign unitry) hington D.C.					
with the Maryland a or 28e-f show Lie notified at Director		City, Town or Location Annapolis			10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
or death with the Maryla there is a critical about the notified at tuneral Director	10e. Street and Number 754 Warren Drive	10f. Zip Code 21	• 403	10g. Citizen of What Co United Star						
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar Armed Forces? 1 Yes 27 No H Yes, Give A Year or Dates:	in U,S. 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Specify Yes o uban, Mexican, Puerto Rican, etc. do Specify:	Specify:						
of 2 should be fined within 72 hours all the and Mental Hydrane. The marked other than "centural", or traumatic event, the Medical Example To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use ret	ne during most of working ired)	16b. Kind of Business/						
tal Hygi d other event, I	17. Father's Name (First, Middle, Last)	Oniciaci	18. Mother's Name (First, Mid		CIOI					
hould be d Menta marked matic ev	Thomas S. Marshall 19a. Informant's Name/Relationship (Type, Print)	10h Mailing Address (Ch.	Clara Weelock	-	Zin Code)					
CHNL	Ida Marshall/ Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town 754 Warren Drive Annapolis, Maryland 2140							
amit. Pages 1 a Apartment of Hea reportant: if Item. iny Injury or othe atics.	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Hillcrest Cemetery 02-29-00 Annapolis, Maryland							
parmit. Departi Importu any inj	22. Name and Address of Fecility John M. Taylor Funeral House 147 Duke of Gloucester Street Annapolis, 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
entificate be executed fing physician and se as the burlal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	to (or as a consequence of): to (or as a consequence of): to (or as a consequence of):								
at the death certified by the attending eteched for use a Physician/Me	Part II. Other significant conditions contributing to death but not	reculting in the underlying cause	oken in Part I 23h	Did tobacco use contributs	to the cause of death?					
	Chronic obstrict	i e ou manar	4	-/	robably 4 Unknown					
Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be deteched.	Cardianyopathy			performed?	Were autopsy findings available prior to completion of causa of death?					
The page				1 Yas 2 No	1 Yes 2 No					
Physician: The this certificate ral director, page TO Be Co	25. Was case referred to medicat axaminer? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient 3 DOA	26. Place of Death (Check of Other:	nly one) Residence 6 D0ther (Spe	oih)					
ath. r: After he fune	27. Manner of Death 1 Tratural 5 Pending (Month, Dey Year 2 Accident Investigation	28b. Time of linjury 28c. Ir		ribe how injury occurred	cny)					
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	2 Accident 3 Suicide 4 Homlcide 6 Could not be determined 28e. Placa of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rundling) 28f. Location (Street and Number or Rundling)									
he Hospital in 24 hours of he Funeral I pletely filled edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner steted.	knowledge, death occurred at the nination and/or investigation, in m	time, date and place, and due to y opinion, death occurred at the ti	the cause(s) and manner as me, date and place, and due	stated. to the cause(s)					
To the comple	29b. Signature and title of certifier	29c. Licr	ense number	29d. Date signed (Month	h, Dey, Year)					
	· lane the MD	D	55 187	2/2	6/00					
	30. Name and address of person who completed cause of death (Annapoli	OYIS QM	Amie Yu, M	1D					
State Registrar	31. Date filed (Month, Dey, Year) 32. Registrar's Si	gnature G. Aspen	61							

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death John Joseph Mankiewicz March 2000 3:30 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 376 Magothy Rd Severna Park Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Deys Hours Min. 1 M 2 □ F 84 215-09-6221 Yrs. Sept. 2, 1915 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Tyes 2 TWO Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 376 Magothy Rd. 21146 USA 14, Rece - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3. Widowed 4 Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Welder 8 Bethlehem Steel 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Matthew Mankiewicz Mary (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Mankiewicz/Wife 376 Magothy Road Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Mar 4, 1 Surial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Hillcrest Memorial 2000 Annapolis, MD Signature of Fuperal Service Lice 22. Name and Address of Facility Barranco & Sons, P.A.Severna Park Funeral Hom 495 Gov. Ritchie Hwy. Severna Park, MD 21146 e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1. Enter the disease, or curshock, or heart failure. List only Approximate Interval Between Onset end Deeth ADDOORCINOMA LUNG ue Cause (Final Due to (or as a consequenca of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown OPD 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 25. Was case referred to medical axaminer? 28. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation

Physician /Medical

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Physician

/Medical

Examiner

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Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Introcramit if item 27 is marked other than "natural", or items 23s or 28s-f show they houry or other traumatic event, the Medical Examines must be notified.

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Box 68760

Division of Vital Records, P.O.

20 director. this funeral death.

Attending Physician: ector or All 24 hours after Funeral Directles Hospital To the Vithin 2
To the Complete

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of contiller

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

MAR 0 3 2000

6 Could not be determined

So Name and address of person who completed cause of death (Item 23a) (Type Print)

WINT. O'KEETS MD 8601 VETERANS HIGHWAY, MILLERS VILLE MD. 21108 32. Registrer's Signeture

28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify)

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner steted.

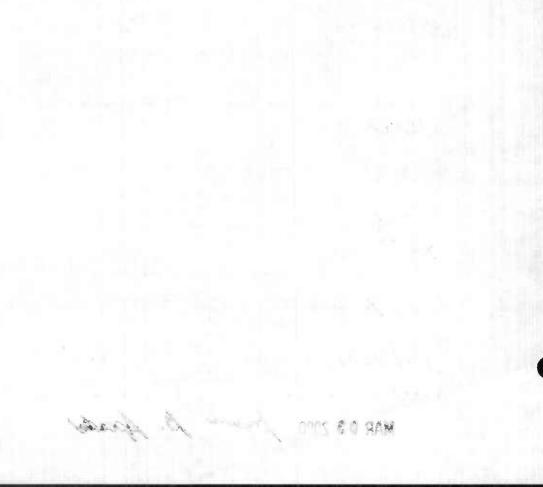
29c. License number

1 TYes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month Yes **Physician** OSEPH 5:55 an lanzo 29, 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Undar 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1₩ M 2□ F 85 173-05-8798 Yrs 1914 Director Pennsylvania Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 28s-t show the Medical Examiner must be notified at 1 Yes 25 No MD Anne Arundel Severna Park Directo 10e, Street and Number 10f. Zip Coda 10g. Citizan of What Country? 312 St. Ives Drive 21146 USA Funeral 14. Rece - American indian, Bleck, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Maritai Status 1 Tyes 2 No If Yes, Give Yeer or Dates: WW II 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Col. in the U.S. Army U.S. Government 5+ 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumeme) permit. Pages 1 and 2 should be till Department of Health and Merial Hy Important: If Item 27 is marked oth any Injury or other trearmatic event BRNs. Be Carmino Manzolillo Tecla Mentana 19e. informent's Neme/Raletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy Manzolillo/Wife 312 St. Ives Drive Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, cremetory or other place) Mar 8 2000 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Suriel 2 Cremetion 3 Removel from State
4 Donation 5 Othar (Specify) Arlington, Va Arlington National Cem. 22. Name end Addrass of Fecility Barranco & Sons, P.A. Severna Park Funeral Home somo 495 Gov. Ritchie Hwy. Severna Park, MD 21146 plications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, one cause on each line. Approximata interval Batween Onset and Death Physician ediate Cause (Final ase or condition iting in death) /Medical piration Examiner Dua to (or as e consequance of): Examiner 500 sician and burial-transi Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaesa or Injury that initiated events resulting in death) Lasf Due to (or es a consequence of): De exec ed by the ettending physician detached for use as the hura Box 68760 Physician/Medical Due to (or es e consequance of) Part ff. Other significant conditions contributing to death but not resulting in tha undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? D.O. 1 Yes 2 No 3 Probably 4 Unknown signed Division of Vital Records, à page 2 should be 24b. Wara autopsy findings evallable prior to completion of cause of daath? 24e. Was an autopsy performed? Completed peen certificate has 2 No 1 Yes 2 No 1 Yes 25. Was casa raferred to medical Be 26. Placa of Death (Check only ona) Hospitel: 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 25 No this 27. Mangar of Death 28d. Dascribe how injury occurred Certification: injury et Work? or Attending Patter death. Director: After to in by the funera Naturai 5 Pending 2 🗆 No invastigetion 1 Yes 2 Accident 6 Could not be 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Stata) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 28e. Piece of injury - At home, ferm, streat, fectory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the bast of my knowledge, deeth occurred et the time, date end plece, end due to the causa(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, data end plece, end due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29b. Signature and title a certifier 29d. Date signed (Month, Day, Year) 29c. License number 2000 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) Franklin Aime 6

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

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	Funeral Director	5. Social Securit 212–45–	-1802	ex 7. A	ge (In yrs. last birtho	Months Days		8. Date of Bir (Month, Da 5-20-9			lace (State or Foreign try)			
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	vith the Me or 28a-fa be notified	10e. Street and				10f. Zip Code			10g. Citizen of V	What Coun	try?			
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	al', or he	3 ☐ Widowe	arried 2 Married d 4 Divorced	Armed Forces 1 Yes 2 2 If Yes, Give Year or Detea	No	13. Was Decedent of I If Yes, specify Cub 1		Rican, etc.)	Blac	ck, White,	etc.			
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,	that the ded by the detached		nificant conditions of	ontributing to death	but not resulting in th	e underlying cause gi	ven in Pert I.		Yes 2 No		the cause of death? bably 4 Unknown			
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IVISION	To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this of completely filled in by the funeral director. Medical Certification: To	27. Menner of De 1 Neturel 2 Acciden 3 Suicide 4 Homicid	5 Pending Investigation 6 Could not be determined	28a. Place of building, to building, to building, to building, to building. To the best liner: On the basis of the basis o	28b. Tim Inju 5:3 ury - At home, farm ic. (Specify)	e of 28c. tnju	ry at mk?) Yes 2 (14)0 Pool 6 me, date end place,	28d. Describe Pessen Strue 281. Location (City or Tot end due to the	cause(s) and ma	method or Rura	Her vehicle ner vehicle Mil Route Number, Son, Md			
•	within 2 To the comple	The first of the control of the cont	nd tipe of entifier	and manner s	M.D	29c. Licen	se number C.M.E		29d. Date signe FEB.	29,				
		()	Tosep	h res	tomes 111 P	_{pe, Print)} enn Street	, Baltimo	ore, Mar	yland 2	1201				
	State Registrar	31. Date and	AR 0 6 2000		rar's Signeture	Land.								

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09720

			Certificate of	Death		g. No.		
Physician	1. Decedent's Name (First, Middle, L				2. Date of Death Month	Day	Year	3. Time of Death
/Medical	David Lee Mo				Februar			8:20pm
Examiner	4a Facility Name (If not institution, ga				Location of Death	4c. County		,
<u> </u>	12309 Foyette		last hirthday) If Under 1 Yea	Upper M		Prince		
Funeral Director	240-88-0345	Sex 7. Age (In yrs. 12 M 2 □ F 43	Months Days			1956		ce (State or Foreign) Land, So
	Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Location				100	d. Inside City Limit
or 28a-f sho be notified a Director	Maryland Prince		per Marlboro					1⊠ Yes 2□N
	10e. Street and Number 12309 Foyette Lar	ne	10f. Zlp Code 20772	2	10	g. Citizen of W United		
by B	11. Marital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	,S. 13. Was Decedent of If Yes, specify Cu		Specify Yes or No- to Rican, etc.)	Blac	American k, White, et Blac	c.
ygiene. we than 'neturn t, the Medical.I Completed	15. Decedent's 1 (Specify only highest g	Education rade completed)	16a. Decedant's Usual Occu (Give kind of work done life. DO NOT use retir	ipation during most of wo	rking 1	6b. Kind of Bu	siness/Indu	stry
mp in	Elamantary/Secondary (0-12)	College (1-4or 5+)	Painter	ed)		Priva	ate	
	17. Father's Name (First, Middle, Las	t)	Tarneer	18 Mothar's Na	me (First, Middle, M			
Mental H srked ob stic ever To Be	Curtis Morrison			Lorrai				
M por	19a. Informant's Name/Ratationship	(Type, Print)	19b. Mailing Address (Street	et and Number or R	ural Route Number,	City or Town,	State, Zip C	Code)
127	Wanza Morrison	/ Wife	12309 Foyett	e Ln. Upp	er Marlbo	ro, Md	. 20	772
If Item 27 or other t	20e. Method of Disposition	Demousl from State	Place of Disposition (Name of cemetery, crematory or other pl	ace)	Date 2	Oc. Location -	City or Tow	
tant	4 Donation 5 Other (Spec	ify) F1	t. Lincoln Cem		3/6/00 B	rentwo	od, M	u •
epartmen sportant ny injury 068	21. Signature of Funeral Service Lion	ptee	Alexande	ress of Facility	Funeral	Homes		
0548	* Xittad	may 11005			e/Foresty		4d. 20	0747
	23a. Part 1. Enter the discuss or con shock, or heart faiture. List only	nulications that ceused the deal	h. Do not enter the mode of dy	ring, such as cerdia	c or respiratory arra	st,		Approximate ntarvat Between
nysician								Onset and Death
Medical	Immediate Cause (Final disease or condition	. Pancreati	c Cancer					
aminer	resulting in death)	8	or as a consequance of):			- 12		
si e		Biliary T	ract Metastasi	LS			i	
g physician and as the bunal-transit	Sequentially list conditions,	Due to (c	or as a consequance ot):					
iclan buria	Sequentially list conditions, if sny, leading to immediate causa. Entar Underlying Cause (Disaase or injury that initieted evants	c					i	
physicials the burner of the b	resulting in death) Last	Due io (o	r as a consequence of):				1	
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y the sched	Part II. Other aignificant conditions	contributing to death but not res	ulting in the underlying ceuse of	iven in Part I.				the causa of deat ably 400 Unkno
detac					10 48	8 2 No	3 Probl	IDIY 445 UNKIN
sate has been signed by page 2 should be detected by P					24a. Was an perform	autopsy ned?	com	re autopsy tinding ilable prior to ipletion of cause sath?
i certificate has b director, page 2 s					1 🗆 Va	s 2 No		Yes 2□ No
ficat or. pa	25. Was case reterred to medicel			26 Place of De				163 20110
director,	examiner?	Hospital: 1 Inpalient 2	ER/Outpatieni 3 DOA	wher:	eath (Check only one Home 5 The Resider		or (Specific	
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or: After the fune cation	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Sulcide 6 ☐ Could not		Injury W	ork? □Yes 2□No				
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	3 Sulcide 6 Could not 4 Homicida determine	28e. Place of Injury - At he building, etc. (Specifical Control of the building) of the building of the buildi	ome, tarm, streat, factory, offici y)	9	28f. Location (Str. City or Town,		er or Rurai	Route Number,
within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification		hysician: To the bast of my kno miner: On the basis of examina and manner stated.						
within Z To the comple	29b. Signeture end Mile of certifier	() 1	29c. Lice	nse number	29	d. Date signer	d (Month, D	ay, Year)
(F)	Molinh	Hoskins, Me		3162		March	3, 20	00
1)	30. Name end address of person who	0.		11 0 0 0			24.1	00701
	Melvin W. Gas		2164 Central A	ve. #220) Mitchell	Lville,	Md.	20/21
State	31. Date filed (Month, Day, Year)	32. Registrer's Signa						
Registrar	MAR 0 6 2000	Between	B. Spark	,				

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State of Maryland / Department of Health and Mental Hygiene 00 0972 | 1

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Physiciar /Medica	1	Gertrude McKin							3	5	2	120	1:00 P. M
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Funeral Director		274-66-7713	6ax 7. A		lest birthdey).	if Under 1		Inder 24 Hrs. ours Min.	8. Dete of Bi (Month, De August	oy, Year,	1936	Counti	ace (State or Foreign ry) rg1a
2 2	-	Usuei Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Loc	ation						10	d. inside City Limits
Med a	101	Maryland Wicomi	СО		Salisbury								1 ☐ Yas 2 ☐ No
Hydrons are used to the man the many and the them the the them the the them the the them the the the the them the the them the them the the the them the the	al Dire	10e. Street and Number 1000 West Road				10f. Zip 6	Code 1801			10g. Ci	tizen of Who	ef Count	y?
f Health and Mental Hygiena. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at To Re Completed by Euroral Disocher	2	11. Maritel Stetus 1 □ Never Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Yas 2 V If Yes, Give Yaar or Datas	No	11	Vas Decede Yes, spaci □ Yas 2		ic Origin? (Sp exican, Puarto ecify:	pecify Yas or No Rican, etc.)	0-	Specify:	America White, e	lc.
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d other		17. Fether's Name (First, Middle, Last,					18.	Mother's Nam	ne (First, Middle	, Maider	Sumeme)		
marked or umatic eve	2	George Roberts, S	r.					Josie B	ell Olive	er			
and emme		19a. Informant's Name/Relationship (rai Route Numb			ate, Zip (Code)
Health orn 27	-	Less McCullars, Jr.	./ son	170				- Salis	bury, M			21801	
nent o		20e. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.		Θ	Piece of Dispos cematary, cram aryland			eme.	Dete 3/13/00		lock,		
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g physician and as the buriel-transit		Sequentially list conditions, if eny, leeding to Immediate cause. Enter Undertying Cause (Diseese or injury	b	Dua to (or as a consequ	uance of):							
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been sign should be									24e. Wes	s en euto ormed?	opsy	ava	re autopsy findings llable prior to apietion of causa eeth?
	5								10	Yes 2	(2KNo	- 10	Yes 2□ No
certificata rector, pag		25. Was case referred to medical					26.	Plece of Dee	th (Check only				
00		axeminer? 1 Yes 2 No	Hospitel: 1 Inpa	tient 2] ER/Outpatient	3 DO	Other:		oma 5□Res		6 Other	(Specify))
5 7		27. Menner of Deeth 1 Naturei 5 Panding 2 Accident Investigation	28e. Dete of In (Month, E		28b. Time of Injury		Bc. Injury at Work? 1 \(\text{Yes}		28d. Describe				
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n 24 hours he Funeral plataly filled	Bollo	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	yelcian: To the bes niner: On the basis end menner:	of examina	owledge, death ation end/or Inv	occurred e estigetion,	t the time, do	ate end pieca n, deeth occu	and due to the	cause(s	s) end mann d place, and	er as sta d due to	ited. the cause(s)
within 2 To the compla		29b. Signature and title of certifier	my a)		29c.	Licansa nur		7		ata signed	Month, E	ley, Year)
		30. Nume and address of person who	completed cause of	deeth (Itel			.0	C	15 BUR		10.0		
6		Joseph N C	MASSO	145	E. CA	RROU	24	246	15 BUR	y	(YYY)		
State		31. Date filed (Month, Day, Year)	32. Regis	trer's Sign	eture	,				t -			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year February 29, 2000 atton of Death 4c. County of Death Peggy L. Mariner 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. Hours | Min. Birthplace (State or Foreign Country) If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Months Days 1□ M 2X F Md. 217-28-4225 Sept. 9, 1932 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No Wicomico Salisbury 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21801-3651 108 Union St. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carrie Twigg Coffin Eddie Coffin 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 57 Pocomoke City, Md. 21851 Lena C. Murphy, Sister 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3-2-00 Cambridge, Md. Cambridge Crematory 22. Name and Address of Facility
Short Funeral Home, Inc. 21. Signeture of Funerel Service Licensee illeani 13 E. Grove St. Delmar, De. 19940 23a. Part. Enter the disease, or complications thet sused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause of each line. Approximete Interval Betwe Onset and Death Immediete Cause (Final disease or condition resulting in death) o d and Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

physician and the burial-transit

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page 2

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After

within 24 hours after deat To the Funeral Director: completely filled in by the

To the I within 2 To the I

death.

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the death certificate be assecuted

Box 68760.

Records, P.O.

Division of Vital Attending Physicien: Important: If Isam 27 any injury or other tr

Physician

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Funeral

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and Mental Hygiena.

Pages 1 and 2 should be

Baltimore, Maryland 21215-0020

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Funeral

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Examiner Physician/Medical þ Completed Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably 4 Vinknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piaca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Magner of Death 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not ba 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide tertifying Phyaician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License numbar

16725

State Registrar

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MARY 03 **DHMH 16 Rev 6/95**

ORIGINAL

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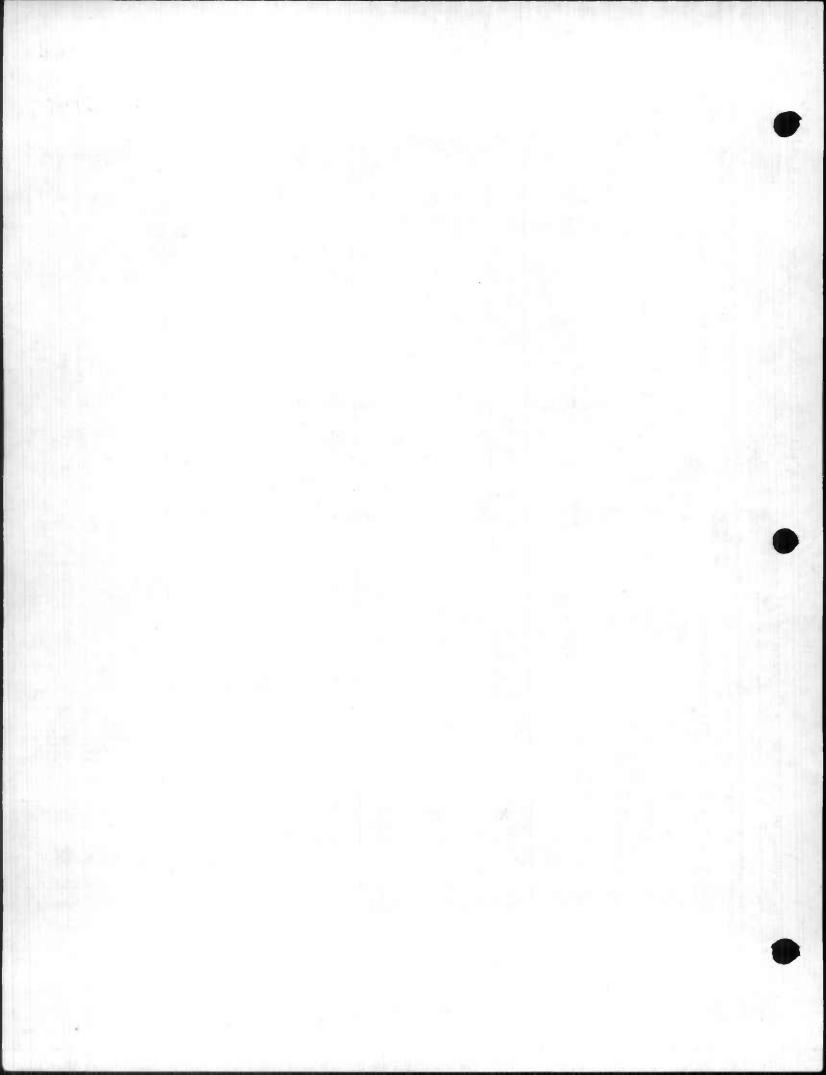
32. Registrar's Signature

Rivers.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONSTANTE

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** Klaus February 25, 2000 4b. City, Town, or Location of Death | 4c. County of Death Hermann Friedrich 12:05PM /Medical 4a Facility Name (If not institution, give street and number) **Examiner** 3303 Old Ocean City Road Salisbury If Under 24 Hrs. † Wicomico If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Hours Deys 1♥ M 2□ F 66 Director April 30, 1933 Germany 305-34-8073 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahona must be notified at 1 ☐ Yes XX No Director 288-1 MD Wicomico Salisury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "naturel", or hams 23a or 3303 Old Ocean City Road 21804 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2 No If Yes, Give 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) Superintendant of Wicomico 12 4 Recreation County Parks 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middla, Last) Be h and Mental ? Is marked of Otto Hermann Ehler Meyer-Cuno Lisa Kühn 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Department of Health as Important: If them 27 is a Phyllis Hudson Meyer/Wife 3303 Old Ocean City Road, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State Salisbury Crematory Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Holloway Funeral Home, Professional Association Kerth 501 Snow Hill Road, Salisbury, MD 21804 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death **Physician** /iviedicai Immediate Cause (Final Chronic Myelogerous levkemia disease or condition resulting in death) Examine Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or es a consequenca of): 8 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 89

that the death certificate be executed physician and s the burial-trans Box 68760 for use as P.O. the 2 signed bed bed Records, has Division of Vital Certification: To or Attending after death. fo the h. within 24 hour. To the Funeral Dh.

8

72 hours after

Pages 1 and 2 should be

altimore, Maryland 21215-0020

						1 ☐ Yes	2,5 No	1 ☐ Yes 2 ☐ No	
25. Was case referr	ed to medical				26. Place of Di	eath (Check only ona)			
examiner?	No	Hospital: 1 ☐ Inpatient 2[ER/Outpatient	3□ DOA	Other: 4 Nursing	Home 5 Residence	6 ☐Other	(Specify)	
27. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	28c.	Injury al Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurre	d	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		home, farm, street	, fectory, of	fice	28f. Location (Stree City or Town, S		r or Rural Route Number,	
29a. Certifier (Check only one)		yalcian: To the best of my kn niner: On the besis of examin and makiner stated.							

29c. License number

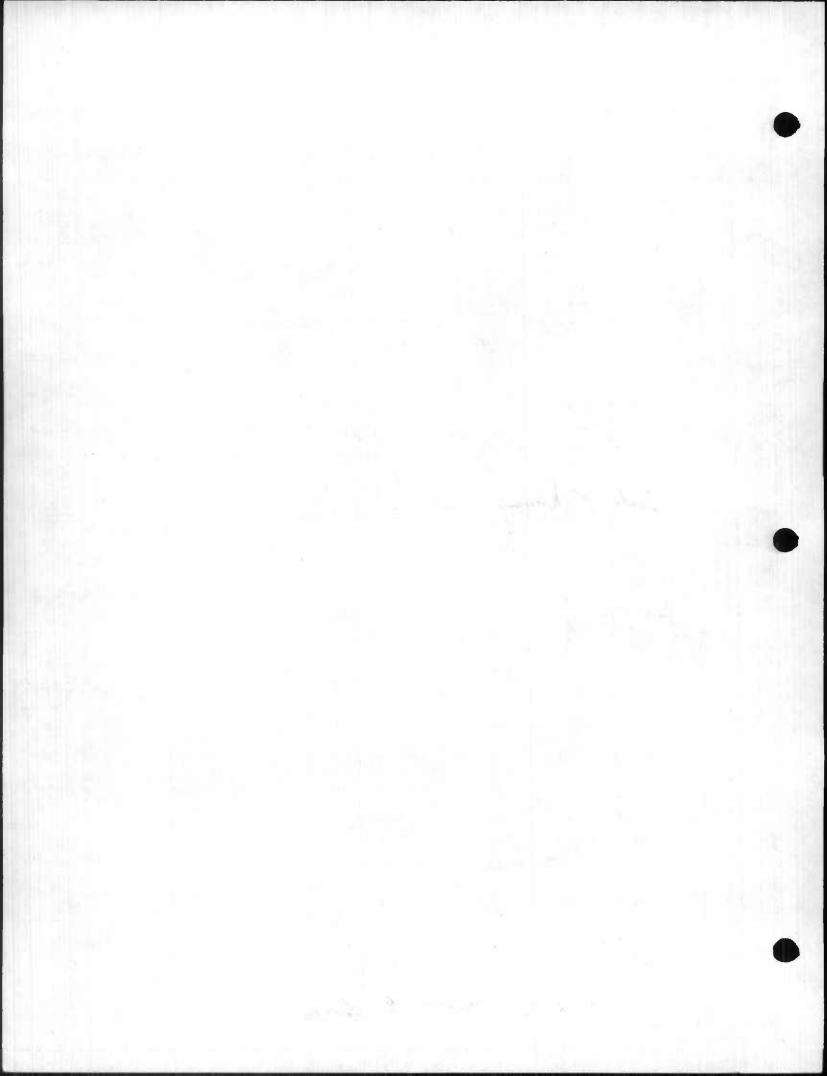
29d. Date signed (Month, Day, Year)

17/6	fat	4.0.	030690		Feb. 28,	2000
30. Name and address of person we Sames E. M.				4. 5.1.	:530-7,	MD.
31. Date filed (Month Day Year)		ar's Signature &.	Sparks			

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edical

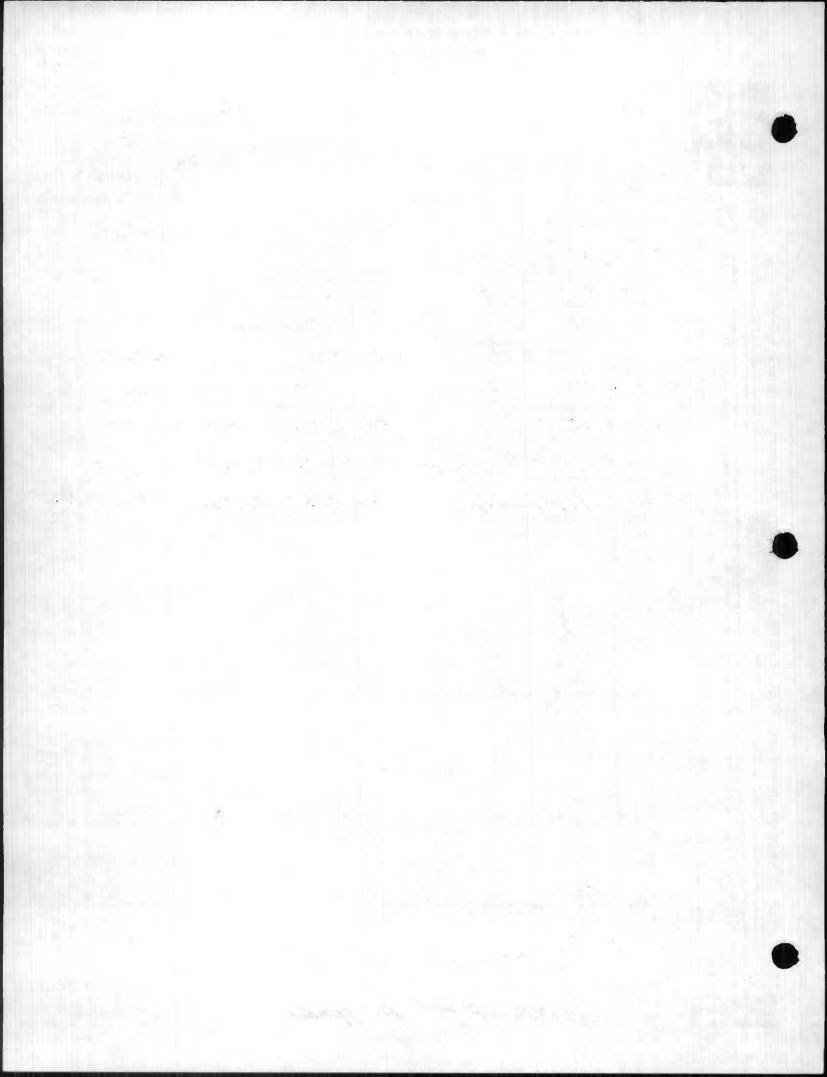
29b. Signature and the of certifier



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 9724

Examiner	OO 6:40 AM County of Death TCOMICO 9. Birthplace (State or Foreign Country)
HERBERT JOHN MCKITTRICK, SR FEB 25, 20	OO 6:40 AM County of Death TCOMICO 9. Birthplace (State or Foreign Country)
Examiner 4a Facility Name (If not Institution, give street end number) 7007 BRANTLEY DR Funeral Director 4b. City, Town, or Location of Deeth 4c. SALISBURY W SALISBURY Funder 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Months Days Hours Min. MAR. 2, 192 Usuel Residence of Decedent	County of Death I COMI CO 9. Birthplace (State or Foreign Country)
7007 BRANTLEY DR SALISBURY SALISBURY Funeral Director 5. Social Security Number 194-18-0371 Usual Residence of Decedent 100 Stets	Birthplace (State or Foreign Country)
5. Sociel Security Number 6. Sex 194-18-0371 15 M 2 F 7. Age (In yrs. lest birthdey) 1 Usuel Residence of Decedent 10 County 1	Birthplace (State or Foreign Country)
ector 194-18-0371 1XI M 2 F 77 Yrs. Months Days Hours Min. (Month, Dey, Yeer) MAR. 2,192	Country)
Usual Residence of Decedent 100 City Town or location	
	2 PENNSYLVANIA
	10d. Inside City Limits
MARYLAND WICOMICO SALTSBURY	1 ☐ Yes 2 ☐ No
8 SIBIBBORI	
	zen ot Whet Country?
7007 BRANTLEY DR 21804	U.S.A.
Armed Forces? It Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
	Specify:
3 Widowed 4 Divorced Year or Dates:	WHITE
15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	nd of Business/Industry
15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) 12 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSURANCE SALES	
12 INSURANCE SALES	INSURANCE
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden	
	GOWAN
19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or	
. So, Bittilli BR. Billi BBCRI, III	21804 cation - City or Town, Stete
1 Burial 2 Cremation 3 Removel from State	DETROIT ONLY OF TOWN, STORE
4 Donation 5 Dother (Specify) ENTOMBMENT WICOMICO MEMORIAL PARK 2/28/00 SAL	ISBURY, MD
21. Signature of Funeral Servica Licensee 22. Name and Address of Facility 705	E. MAIN ST.
BOUNDS FUNERALL HOME, TINC. SALI	SBURY MD 21804
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,	Approximate
shock, or heart tailure. List only one cause on each line.	interval Between Onset and Death
immediete Ceuse (Final	
disease or condition resulting in deeth)	3 mor.
Due to (or as e consequence ot):	
_ b	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es a consequence ot): Due to (or es a consequence ot):	
that initiated events sesulting in death) Lest Due to (or es a consequence ot):	
Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence ot):	
d	1
Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco	use contribute to the ceuse of death?
4 T Vac 6	□ No 3 □ Probably 4 □ Unknow
1 Tes 2	vvozor, v_onklow
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco 1	24b. Were eutopsy tindings
24e. Was en eutor performed?	availeble prior to completion of cause of deeth?
	of deeth?
1 □ Yes 24	No 1 ☐ Yes 2 ☐ No
25. Was cese reterred to medicel examiner? 26. Piece of Death (Check only one)	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	3 ☐Other (Specify)
27. Manger of Deeth 28e. Date of Injury 28b. Time of 28c. Injury et 28d. Describe how injury	y occurred
1 Naturel 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
3 Suicide 6 Could not be determined 28e. Plece of Injury: At home, farm, street, fectory, office 28f. Location (Street en	d Number or Rurel Route Number,
4 Homlcide building, etc. (Specify)	
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s)	and manner as stated
Check only Check only Chec	pleca, end due to the cause(s)
b	e signed (Month, Day, Year)
	/
12 rale 19.0- 029/68 2/.	25/00
30. Name and address of parson who completed cause of death (ttem 23e) (Type, Print)	
ROBERT ALLEN 100 POWER ST., SALISBURY M	10 2/201
24 Date March Day March Day March 20 Designation 4	
State Strar FFB 2 8 2000 Service Signeture Strar	

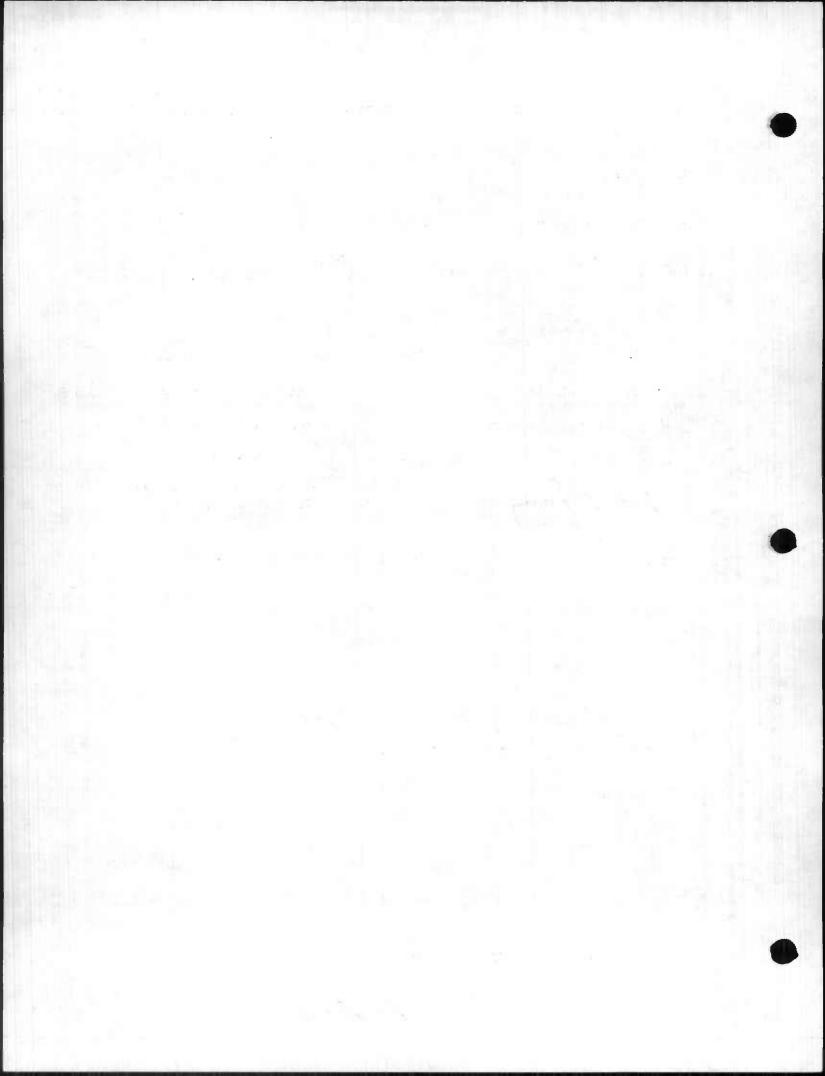


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Year Month **Physician** Elmira Margaret Massey February 24th 2000 8:38 pm /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury Wicomico If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Yrs. Director 217-07-2398 98 October 13, 1901 Princess Anne, MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exercises must be notified at 1 Yes 2 No Directo Wicomico Maryland Willards 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7327 Main Street 21874 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White P 3 □ Widowed 4 □ Divorced Hygiene. other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Manhatten Shirt Department of Heelth and Annual Hygiens Important: If ham 27 is marked other than any injury or other traumatic avant, than 2018. 10 Floor Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0 William Carolyn Robert Heath Mollie Messick 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin J. Massey/Stepson 36079 Mt. Pleasant Road, Willards, MD 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ABurial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Hope Cemetery 2/29/2000 Willards, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Kerth 501 Snow Hill Road, Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Viterioscleratie Carlisvascula Immediate Causa (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last and Due to (or as a consequence of): Box 68760. physician Physician/Medical 94 Dua to (or as a consequence of): for use as Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. the signed by t 1 Yes 2 No 3 Probably 4 Unknown ρ Records. 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No of Vital Attanding Physician: 8 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Moursing Home 5 Residence 6 Other (Specify) 1 Yes 2₺ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide ò 29e. Certifier 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the F within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifian Regard 2-25-2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregorio Belloso 5302 Chinaberry Drive Salisbury, MD 21801 32. Registrar's Signature State 8 2000

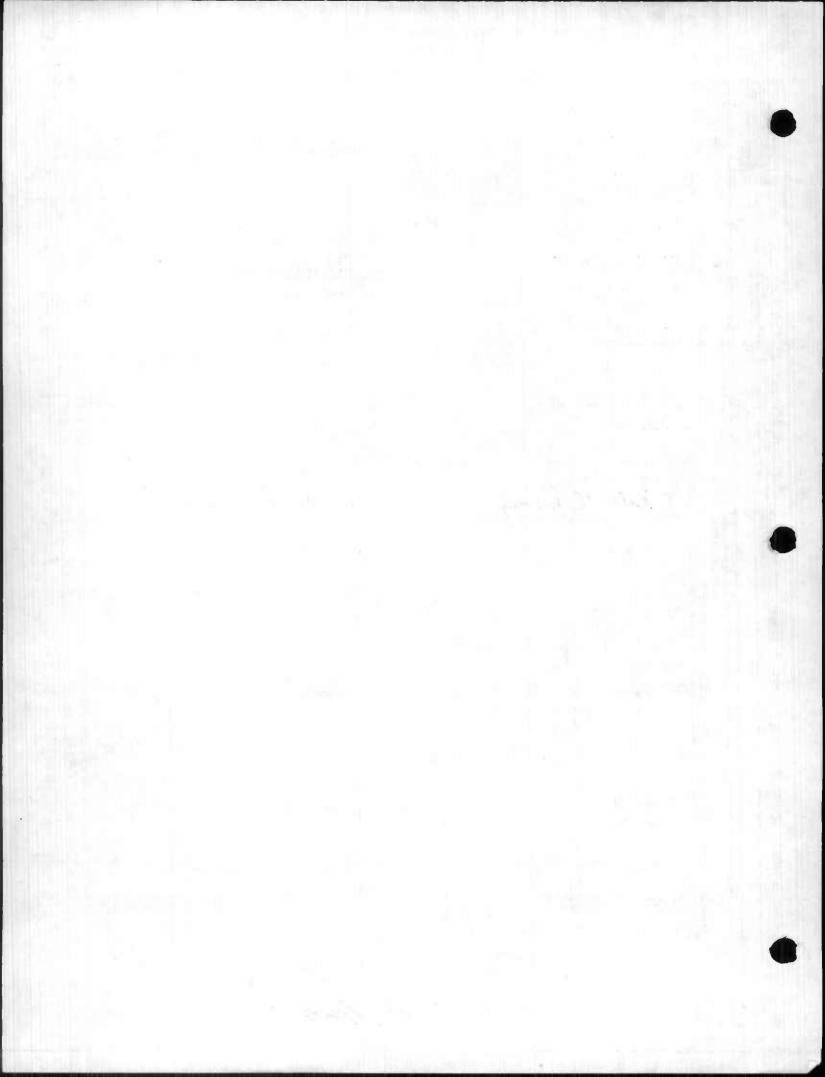
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 00 09726

			Ce	rtificate	of Death	R	eg. No.	0011	
	1. Decedent's Nama (First, Middle, La	st)				2. Date of Dea			of Death
Physician	MYRTLE MAE	MALCO	L.M			Month FEB	24,2000	Year 3:30	OPM
/Medical Examiner	4a Facility Nama (If not institution, giv		OL1		4b. City, Town,	or Location of Death	4c. County of		0211
Examine	SALISBURY CENTER	CENESTS FID	FDCADE		SALTSE	BURY, MD.	wicomi	ico	
-	5. Social Security Number 6. S		s. last birthday	If Under 1					a or Forei
Funeral Director		DM akie	84 Yrs.			lin. (Month, Day	1, 1915 S	9. Birthplace (Steta Country) Silcam, Mary	yland
B 10	10e. Stata 10b. County	10c.	City, Town or L	ocation				10d. Inside	City Lim
or 28s-fah Se nordfed Director	Maryland Wicomi	co s	alisbur	-				Λ	s 2 🗆 l
	10e. Street and Number 200 Civic Avenue			10f. Zip C	1801	1	0g. Citizen of W	hat Country?	
r. or he by Fur	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deceder If Yes, specify 1☐ Yes 2[nt of Hispanic Origin? Cuban, Mexican, Pu Mo Specify:	(Specify Yas or No- earto Rican, atc.)		- American Indian, k, Whita, atc. White	
ygiene. or than "natural", r, the Madical East Completed by	15. Decedent's Ed	lucation	16a. Dece	dent's Usual (Occupation	undina	16b. Kind of Bus	sinass/Industry	
than 'n	(Specify only highest gra	College (1-4or 5+)	lifa.	DO NOT use	done during most of (retired)	working			
omp	7		Do	mestic			House	wife .	
	17. Father's Nama (First, Middle, Last)					Neme (First, Middle,			
Ked of o	Roland	0	troll		C-11			meral c	
marked marked	19e. Informent's Name/Relationship (twell	ing Address /	Street and Number or	Bural Boute Numbe	City of Town	Taylor	
		ypo, rinnj							
tem 27 other tr	Bruce Malcom/Son	lane	Place of Disp		cean City				ŀ
2 2 2	20a. Mathod of Disposition 1 Description 2 Cremation 3 C		cometery, cre	metory or oth	er place)	Data	20c. Location - 0	City or Town, Steta	
Department of Inportant: If its eny injury or of boos.	4 □ Donation 5 □ Other (Specifi) Sp	ringhil	1 Memo	ry Gardens	3 2/28/200	O Hebro	on, Maryl	and
200	21. Signature of Funeral Service Licer	Ş00			Addrass of Facility				
SESS	1 211 06		H	Iollowa	y Funeral	Home Prof	essiona.	l Associa	tio
	23a. Pert1. Enter the disease, or com	aver	5	ou sno	w Hill Roa	ad, Salisb	ury, MD	Approxim	
g physician and es the burlet-transit fedical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec		forg	dix eco.		gr	-
d by the attending letached for use es		d							
ysle	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	underlying cau	se given in Part I.	23b. Dld to	obacco uae con	tribute to the cause	e of dea
igned by the be detached by Physic	Deakfe	7				_ 1DY	es 2/0 No	3 Probably 4	Unkn
2 should			4			24a. Was a perfor	in autopsy med?	24b. Wara autops available prio completion of of death?	or to
page Com						1 🗆 Y	as 2 No	1 ☐ Yes 2	□ No
£ 0 0	25. Was case refarred to medical				26. Place of I	Death (Check only or	na)		
9 0	examiner? 1 Yas 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 Nursin	g Home 5□ Resid	ence 6 □Otha	r (Specify)	
5 7	27. Manner of Death	28a. Date of Injury (Month, Day Year)			Injury at Work?	28d. Describe h			
C # C	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2 No	281 Location /S	treet and Numbe	er or Rurel Routa Nu	umber
To the Funeral Directicompletely filled in by I	4 Homicide determined	building, etc. (Spe	cify)			City or Tow	n, Stete)		
mpletely filled	29a. Cartifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my k liner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred et evestigation, in	the tima, data and pla my opinion, death o	ace, end due to the c ccurred at tha tima, d	ause(s) and mar ata and place, a	nner as stated. Ind due to the cause	e(s)
To the comple	29b. Signatura and titla of certifier	1 19		29c. l	icense number	2	9d. Data signed	(Month, Day, Year))
3	1 2 74	1/1/		-	-29349		2/20	Zin	
	////	111			-23343		100/	61	
	30. Nama and address of person who					03051	-		
	WILLIAM ROBINS, M	.D.,1104 HEAL	THWAY I	DR.,SAL	ISBURY, MI	21804			
State	31. Data Tiled (Month, Day, Year)	32. Registrar's Sig	pature	4	,				



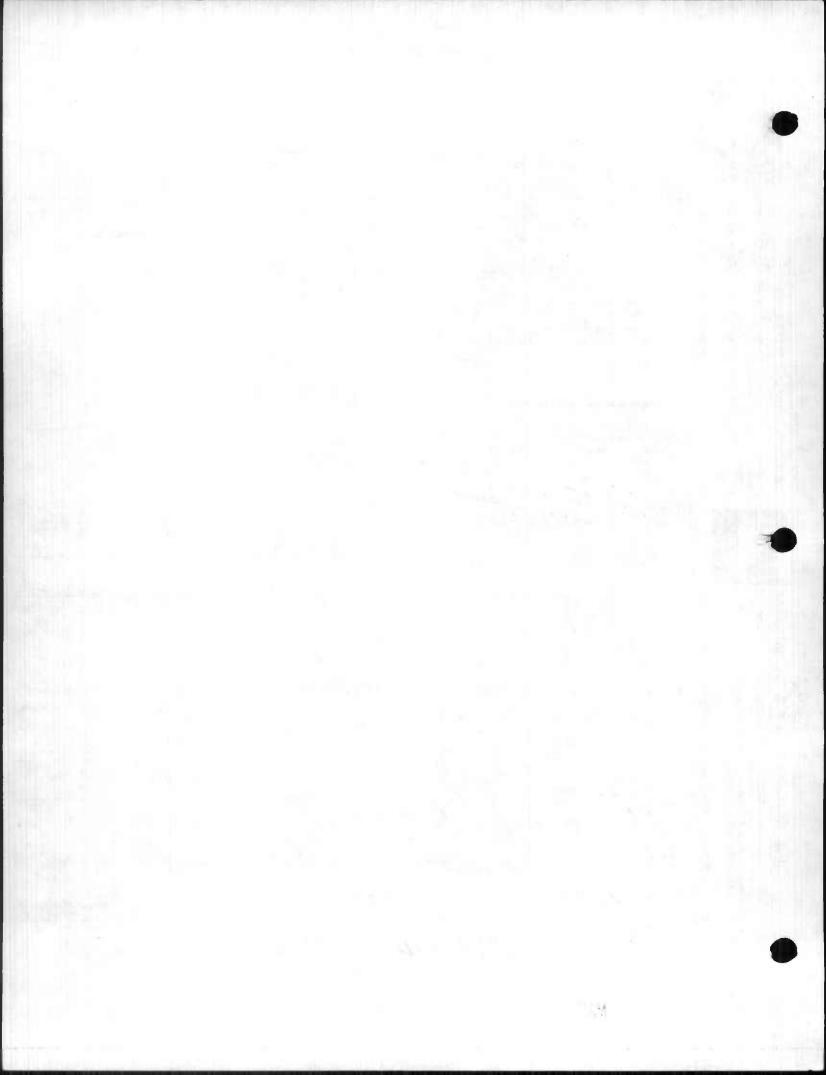
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** March 6, 2129 E11a Monroe Rosa 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Talbot Easton 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1□M 2MF Days Hours Yrs. Director 86 Nov.9,1913 213-18-4340 Maryland Usual Residence of Decedent the Maryland r 28a-f show 10s State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Director Maryland Cordova Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 21625 Council Road 21625 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or her any injury or other traumatic avent, the Medical Example and place. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Monroe Specify à 3 ⊠ Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Home Maker Someone else's home Ella Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 2 Asbury Groce E11a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa 10245 Council Rd., Cordova, Maryland 21625 Albert Monroe, Jr. son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/12/00 Easton, Maryland Chape1 Cemetery 22. Name and Address of Facility
Bennie Smith Funeral Home
P.O.Box 1687, Easton, Maryland 21601 21. Signature of Funeral Sension Liganoper 23a. Part1. Enter the de shock, or heart fail that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) **Titledical** Examiner Examiner mary physician and a the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of): signed by the attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate as or Attending Physician: The star deeth.

Si Director: After this certificate ed in by the funeral director, pe of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital on 24 hours aff
 Funeral Di
 Interly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of purpose who completed cause of death (from 23a) (Type, Print) Carolyn Helmly M.D., 606 Dutchmans Lane, Easton, Maryland 21601 31. Date filed (Month, Day, Year)
MAR 1 0 2000 32. Registrar's Signature State Registrar

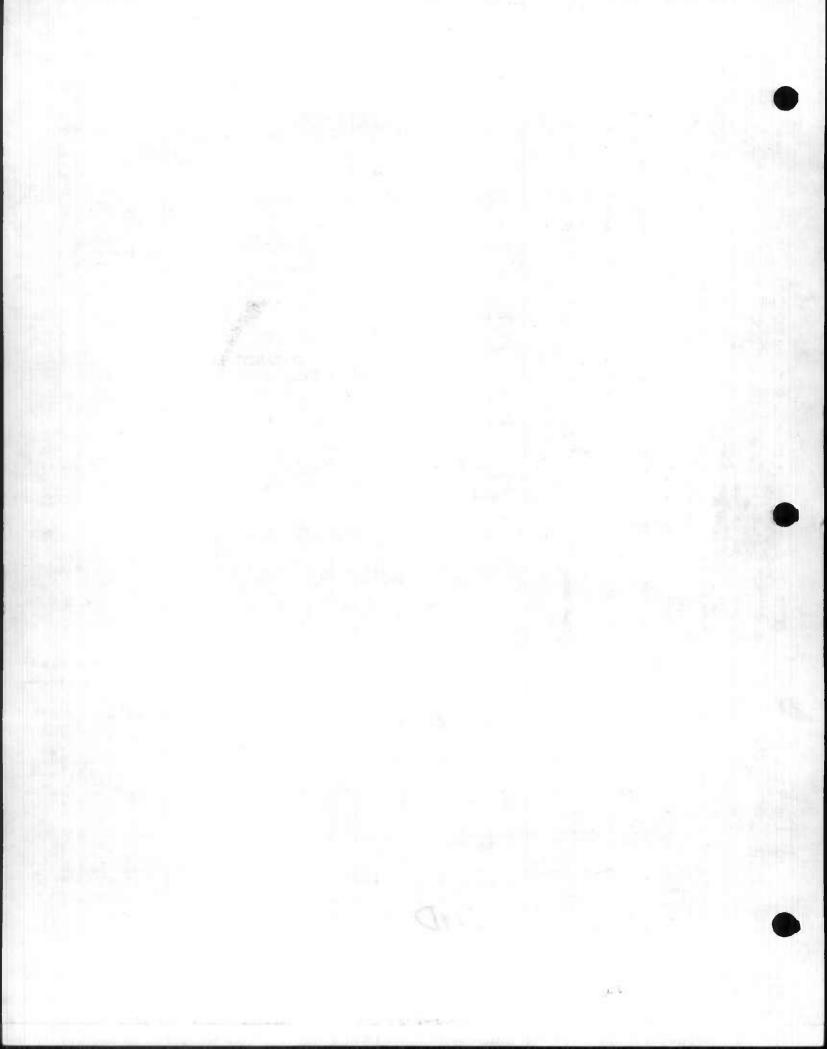
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 09728

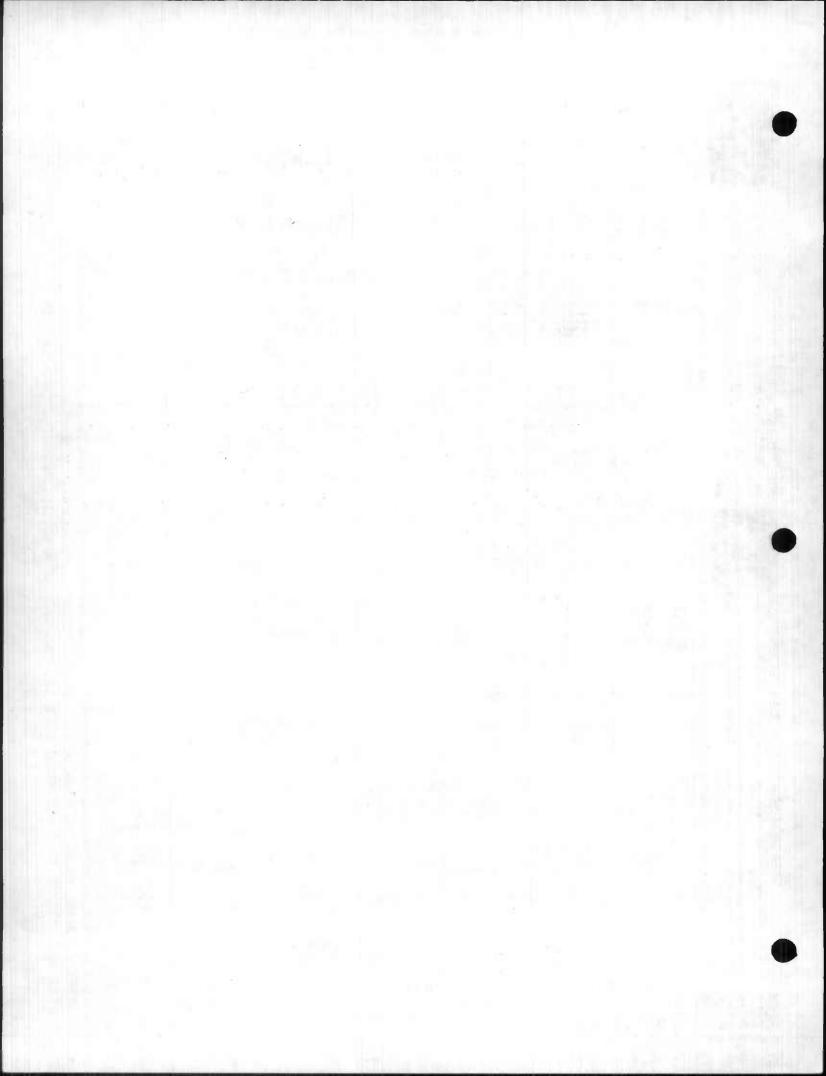
					Ce	rtificate	e of	Death			Reg. No.			
	1. Decedent's Name (Firs	t, Middle, Las	1)					2 11		2. Date of De Month	eath Dev	Yeer	3. Time of Death	
Physician /Medical	LOUISE	VIRGIN	NIA M	Ic CARTY					V	iarch	3. 200		0248	
Examiner	4a Facility Name (If not in	stitution, give	street and n	umber)				4b. City, To		ation of Deat			10210	
	The Memo:	rial H	Hospi	tal			1	Easto	on		Talbo	t		
Funeral	5. Social Security Number	6. Se	ex .		. last birthday)	If Under				8. Date of Bi (Month, Di	-Afr		place (State or Foreign	
Director	219-74-7912	1[□M 2∭ F	89	Yrs.	MURITS	Days	Hours	Milit.		25. 1911		RYLAND	
9	Usual Residence of Dece			140.0										
deeth with the Maryland rins 23a or 28a-f ehow rins 15a or 18a-f ehow rins 15a or 18a-f ehow rins 15a or 18a-f ehow		County		10c. C	ity, Town or Lo	ocation						1	1 ☐ Yes 2 No	
oto cto	MD	TALBOT			EAST	ON							1 Tes 2MNo	
vith the Mar t or 28e-f el be notified Director	10e. Street and Number					10f. Zip					10g. Citizen of V	What Cour	ntry?	
23.8	29991 MATT	CHEWSTO	OWN ROA	AD			216	601			US	SA		
ural, or frame 23a or 23e-f ehom il Estatible met be positied at ed by Funeral Director	11. Marital Status		12. Was Dec Armed F	cedent Ever in U	J,S. 13.	Was Decede	ent of h	lispanic Ori	igin? (Spec	Specify Yes or No- rto Rican, etc.) 14. Rece - American Indian, Black, White, etc.				
88		-		2 No		1□ Yes 2						7.1	HITE	
0		ivorced	Year or I	Dates:				Opcomy.		Specify: WHITE				
n, the Medical	15. D	ecedent's Edu highest grad)	16a. Dece	dent's Usual	Occup k done	nation during mos	t of working	16b. Kind of Business/Industry				
dwo	Elementary/Secondary			(1-4or 5+)	life.	DO NOT us	e retire	d)						
TO O	8		-0)-	HOM	[EMAKE]	R				OWN I			
	17. Father's Name (First,										, Maiden Suman			
ToB	WALTER HOWA	ARD GAR	RDNER			- 05		ELI	IZABE'	TH ELL	INS			
2 2	19a. Informant's Name/Re				19b. Maili	ng Address	(Street	and Numbe	er or Rural	Route Numb	Code)			
other tr	WILLARD LEF		RTY / S	SON				WSTOWN	N ROAL		TON, MD			
6	20a. Method of Disposition		Domoual Inom		Place of Dispo cemetery, crea	osition (Nam matory or ot	e of her pla	09)	į	Date	20c. Location -	City or To	own, Stete	
	4 Donation 5 Other (Specify) SPRING HILL CEMETERY 3-6-00 EASTON											MD		
mportant: any injury ance.	21. Signature of Funeral S	Seprita Licens	ge /										Buth Calls I	
Eag	1 / Many	7/	//	. 21 (FEDFE	LLOWS	, H	ELFENI	BEIN	& NEWN	AM FUNER	RAL H	OME, P.A.	
	23a. Part1. Enter the disc	ase or comp	fications that	caused the dea							N, MD 21	601	Approximete	
	shock, or heart tailur	e. List only o	ne cause on	each line.			0.0,-	19, 00011 20		toopo.o.y	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	Interval Between Onset end Death	
ician dical	Immediate Cause (Final		17		1	11	/	/	-	- 1				
iner	disease or condition resulting in death)		a. C'	onge	Stive	- 14	ea	1+	tai	eller	1		Jeans	
- i			1	Dyle to (or as a conse	quence of):		. 1	-7	- /		1	1 1	
			b. AC	ute	Mag	oca	ed	eal	4	yas	Chor	1 ;	3 days	
as the burletraneit	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	s.	1	Due to (or as a consec	quence of):				1)				
3 m	cause. Enter Underlying Cause (Disease or injury	2	c. 60	rona	res	Ar	fer	in	01	Seas	26	i	hears	
P	that initiated events resulting in death) Last			Due to (or as a consec	quence of):		1					0	
2			d.											
- E												1		
Physician/	Part II. Other significant of	conditions co	ntributing to d	seath but not re-	sulting in the u	inderlying ca	use giv	ven in Pert I	l.	23b. Did	tobacco use co	ntribute t	o the cause of death	
by Physician										1 🗆	Yas 2 No	3 Pro	bably 4 Unknow	
leted by														
Be Completed										24a. Was	an eutopsy ormed?	24b. W	ere autopsy findings railable prior to	
9										1		00	ompletion of cause death?	
Eo										10	Yes 2ENo	11	□Yes 2□No	
Ü	25. Was case referred to	nedical						26 Plans	a of Dooth					
	examiner?		Hospital:	h	TERIO de elle	all no.	Ott	nor-		(Check only		(C	4.0	
: To Be Com	1 Yes 2 No			-	28b. Time o		1	4 LI NE			how injury occur		(y)	
Certifications	1 Natural 5	Pending investigation	(Mor	of Injury oth, Day Year)	Injury	м	Woo	rk? Yes 2		00.000.00				
2	✓2 Accident 3 Suicide 6 □	Could not be	28e Place	e of Injury - At h	ome farm et					Rf Location	(Street and Numb	or or Run	al Route Number	
T	4 Homicide	determined	build	e of Injury - At h ling, etc. (Speci	ify)	ibot, ractory,	UIICE		-		wn, State)	or or right	or ricete rember,	
Ö	200 Codifice	-44 64	-1-1 T1	had faile										
completely filled in by the funeral Medical Certification: 1	(Check only 2 M	ertifying Phys edical Exami	iner: On the b	pasis of examina	owledge, deat ation and/or in	h occurred a vestigation,	t the tir in my c	me, date an opinion, dea	nd place, ar ath occurre	nd due to the d at the time,	cause(s) and ma date and place,	nner as s and due t	stated. o tha ceuse(s)	
eld in	one)	and Mary	and mar	mer stated.		200	1 inner	a aumbas			00d Data sinns	d /Manth	Day Mand	
3	29b. Signature and title of	/	110	11.	10			se number			29d. Date signe		Day, rear)	
	Cari	1/2- 1	Helr	My M	1	1	10	053	300	2	3/3/	00		
	30. Name and address of	person who co	ompleted cau	se of courth (Ite	m 23a) (Type,	Print)								
	CAROLYN HEL	MLY, M	I.D., 6	06 DUTO	CHMAN'S	LANE	E	ASTON	MD '	21601				
State	31. Date filed (Month, Day			Registrar's Sign	ature									
Registrar	MAR	0 6 20	100	1	fol.	· plife	and	621						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 09729

			Ce	ertificate d	of Death		Reg. No.		
	1. Decedent's Neme (First, Middle, La	st)				2. Date of I	Death Day	Year	3. Time of Death
Physician /Medical	Mary Collings Mc	Cauley					11, 2000		10:22 PM
Examiner	4a Facility Name (If not institution, giv				4b. City, To	wn, or Location of De			
	125 Carters Mill	Road			Elkto	on	Cec	eil	
Funeral	5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday	If Under 1 Y	ear If Under	24 Hrs. 8. Date of I			lace (State or Foreign try)
Director	221-09-0619 Usual Residence of Decedent	10 M 20 F 82	Yrs.	Months De	bys Hours	Min. (Month, Novemb	er10,191	Del.	aware
M P M	10s. State 10b. County	10c. Ci	ty, Town or l	ocation			7	1	Od. Inside City Limits
or 28a-f sh or 28a-f sh be notified.	Maryland Cecil	12	5 Cart	ters Mil		, Elkton	10g. Citizen of V	Afhat Coun	1 ☐ Yes 2 No
4 24 0	125 Carters Mill	7		2	1921		United	l Sta	tes
- 2 EG Z	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2X No If Yes, Give Year or Detes:	I,S. 13	Mes Decedent If Yes, specify (igin? (Specify Yes or I n, Puerto Rican, etc.)	Specify	e - Americ ck, White, Wh	
Maryland 21215-0020 3.2 should be liled within 72 hours at and Mental Hygiene. The marked other than "natural", or reumetic event, the Medical Exam To Be Completed by 1	15. Decedent's Ed (Specify only highest gra	ade completed)	/Giv	edent's Usuel Or e kind of work do DO NOT use re	one during mos	t of working	16b. Kind of Bu	usiness/Inc	Justry
Pare om	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemak			in h	ner o	wn home
D BEER O	17. Father's Name (First, Middle, Last,			Homeman	-	er's Neme (First, Midd			wit Home
dbe ddbe ddbe ddbe ddbe ddbe ddbe ddbe	William Morroy	Collings			٨٨٠	a Dora Hof	fman		
To To	William Merrey 19a. Informant's Name/Relationship (19h 14ai	linn Address (Ch		er or Rural Route Nun		State Zin	Code)
Mar d 2 sh m and 7 is m treum									
B. N. Tand	Robert G. McCar		Place of Disc	Carters position (Name o	MillI	Road, Elkt	on, Mary		
altimornant. Pages partment of Poortant: If he rinjury or of the contract of t	1 A Burial 2 Cremation 3 C 4 Donation 3 Other (Specific	Removel from State No	cemetery, cre	ematory or other ast Meth	place)			-	, Maryland
Balt Partie	21. Signature of Funeral Segrice Licer	1	meters	22. Neme end Ad	dress of Facilit	ty	0.0		
00 88558	Molode			couch Fu 27 South	Main	street, No	rth East.	Mar	yland 21901
Physician	23a. Fart1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.			dying, such as	cardiac or respiretory	errest,	1	Approximate Intervel Between Onset and Death
/Medical	Immediate Cause (Final disease or condition	ALZhe	1111	2.5.					570,25
Examiner	resulting in death)		or es a conse					1	1,
je de la constant de		0.000	01 03 8 00130	squerioe orj.				1	
requires that the death certificate be executed requires that the death certificate be executed been signed by the attending physician and hould be datached for use as the burist-transit atted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (d	or as e conse	equence of):					
68760, filoste be an physician as the burial	that initiated events	C. Due to /c	or es e conse	randoce of).				-	
ding phy	resulting in death) Last	d	ar es e conse	quarica ory.					
Box esth cert attendin for use								- 1	
18, P.O. BOX res that the deeth ce signed by the attends I be detached for use by Physician/	Part II. Other significant conditions of	ontributing to death but not res	ulting In the	underlying cause	given in Pert i		d tobacco use co		the cause of death?
of Vital Records, Physician: The law requires the this certificate has been aignented director, page 2 should be considered by 1: To Be Completed by						24a. W	as an autopsy rformed?	avi	ere autopsy findings allable prior to
The law requirement of the second of the sec								of	mpletion of cause death?
Vital I	00.111				- 11		Yes 2000	10	Yes 2 No
Vita licien licien rector	25. Was case referred to medical examiner?	Hospitel:			Othor	of Deeth (Check on			
this of T.	1 Yes 2 No	1 Unpatient 2 L	ER/Outpatie		40140	ursing Home 5,2 Re			γ)
Division of Vita as to Attending Physician: a star deeth. I Director: After this certification in the function of in by the funeral director. Certification: To Be (1 Natural 5 Pending 2 Accident investigation		28b. Time Injury		njury et Work? 1 🗌 Yes 2 🗍		e how injury occur	reu	
Division or Attending after death. Director: Attending d in by the func-	3 Suicide 6 Could not be determined	e 28e. Plece of Injury - At h building, etc. (Specif	ome, ferm, s fy)	treet, fectory, off	ice		(Street and Numb Town, State)	per or Rura	l Route Number,
Division or transfer or the Hospital or Attanding Philip 24 hours after deeth. To the Funeral Director: After the complete of filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dee ition end/or i	th occurred at th nvestigation, in r	e time, date an ny opinion, dee	d place, and due to the time	ne cause(s) and mi e, date end place,	anner as st and due to	tated. o the cause(s)
Withir Comp	29b. Signature and title of certifier	K			ense number		29d. Dete signe		
	18.650	1 2000		1	015	5-6.	13 m	421 0	zeec .
10	30. Name and address of person who	completed cause of death /tter	n 23a) (Tvo					-	
12	Robert Gray MD	204 South Sta			Marula	nd 21921			
State	31. Date filed (Month, Day, Year)	32. Registrer's Signa		KCOII,	IIGI y Id	114 21721			
Registrar	MAR 1 3 2000	panera &	1. 1	souls					



State of Maryland / Department of Health and Mental Hygiene 00 09730

Physician						,		Death			leg. No.		
Physician	1. Deced	ent's Nama (First, Middl	a, Last)		HI WILL					2. Data of Dea		Van.	3. Tima of Dee
	E1:	izabeth A	nn Perr	y Maze	9					Month	12,200	Year	13:45P
/Medical Examiner		y Nema (If not institution					4	b. City, To	wn, or Lo	cation of Death			10.101
Cxammer		Bridge C	The state of the s		litati	on		Elkt	on		Ceci	1	
		Security Number	6. Sax		rs. last birthday		1 Year	If Undar		8 Date of Birt			iaca /Stata or For
Funeral			1□M 2√2		Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day		Cour	placa (Stata or Foi ntry) nsylvan
Director		-16-9990 sidence of Decedent		/0	-					VECEM BE	e 4.1921	rem	ISYLVAII
B B	10a. State			10c.	City, Town or L	ocation		****				1	0d. Inside City Lir
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5 23 5	1.4	Transom C											
thems thems	11. Marite	al Status	12. Was E	Decedent Evar in 1 Forces?	U,S. 13.	Was Deced	dent of H cify Cubs	ispanic Orl n, Maxican	gin? (Sp , Puerto	ecify Yas or No- Rican, atc.)		ck, Whita,	
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542		Donation 5 Other (S		D	nmacu1	mete:	rv	epti	.0113	/17/00	Che:	rry	Hill, Mc
Departmen Important: any Injury pnce.	21. Signa	ature of Funeral Service	Licensee	11	2	Nama ar	nd Addre		,				
8 5 8	-	72h	40							neral			
	23a Por	11 Enter the dispass of	complications th	at caused the d	eath Do not an	59 E	Ma te of dvin	in S	cardiac	Elktor	Md.	219	21 Approximata
	sho	t1. Enter the diseese, or ck, or haart tailura. List	only one cause	on each line.	patri. Do not an	ital tila tiloc	ao or dyn	9, 30011 03	OBI GIGO	or raspiratory ar	1001,		Intarval Batweer Onsat and Deat
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Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 9731.

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4	Examine	1	Laurelwood			-					Elkt	on			Ceci			
_			5. Social Security Number	8. S			(In yrs. last	hirthday)	If Under	1 Year			R Date of Ric				ana /State	a or Enraian
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	esth certificate be executed attending physician and I for use as the burial-transit	edical Examiner			b	. 6	to force	11	11	V	1	-		-		-	Ju	
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ō	Phys rethis		27. Manner of Death	-	28a. Date (Mo	-		b. Tima of		28c. Inju		arsang rac	28d. Describe				,	
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	State	9	31. Data filed (Month, Day, Year,)	32.	Registrar	's Signatura	-		-								
	Registra	r	MAR 0 9 2000		Mener	w	19	11	a. V.	1								

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Lest) MARCH Year PETER MASON 10000 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Death Northwest Hospital Center Randallstown Baltimore County If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 XM 2□ F Months Days 93 Yrs. 214-03-6764 May 23, 1906 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Carroll Sykesville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7309 Second Avenue 21784 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 2 Year or Detes: 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispenic OrigIn? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Banjo Player / Laborer Music/Maintenance 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Peter Broox Mason Martha Ellen Lovell 19a. Informent's Neme/Reletionship (Type, Print) (Grand-Mrs. Rebecca Tacchetti daughter) PO Box 27 Lisbon, MD 21765 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 20b. Plece of Disposition (Neme of cemetery cremetory or other produced Cemetery) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1X Buriai 2 ☐ Cremetion 3 MRemovel from State 3/18/2000 Martinsville, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) 21. Signeture of Funeral Service Licanses Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications travcaused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause or each line. Approximete Interval Between Onset end Deeth fmmediate Ceuse (Finel disease or condition resulting in deeth) alvanous Due to (or es e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): that initieted events resulting in death) Last Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert It, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were eutopsy findings available prior to 24e. Wes an eutopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Directo

Funeral

þ

Completed

MD

Funeral

Director

Examiner must be a

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturer", or Items 23/4 eny Injury or other traumatic event, the Medical Exportant Insulation bonds.

with the Maryland r 28a-f show

> ician and burial-trans physician a Se attending the 5 Deed 188 certificate director, this

The law requires that the death certificate be executed

Box 68760.

Records, P.O.

Division of Vital

Physician:

or Attending

Hospital

efter death.

Examiner Physician/Medical g Completed Be 20 Certification:

edical

: After this funeral within 24 hours efter death To the Funeral Director: J completely filled in by the

Dealert

25. Was case referred to medical exeminer? 1 Yes 2 No

27. Menner of Deeth 5 Pending investigation Neturel 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

31. Dete filed (Month, Dey,

Hospitei: 1 Inpatient

28e. Dete of injury (Month, Dey Year)

M

28b. Time of

2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work?

1 ☐ Yes 2 ☐ No 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one)

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner as stated. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end menner stated.

29b. Signeture end title of carfifier

29c. License number

29d. Date signed (Month, Day, Year) , Jours

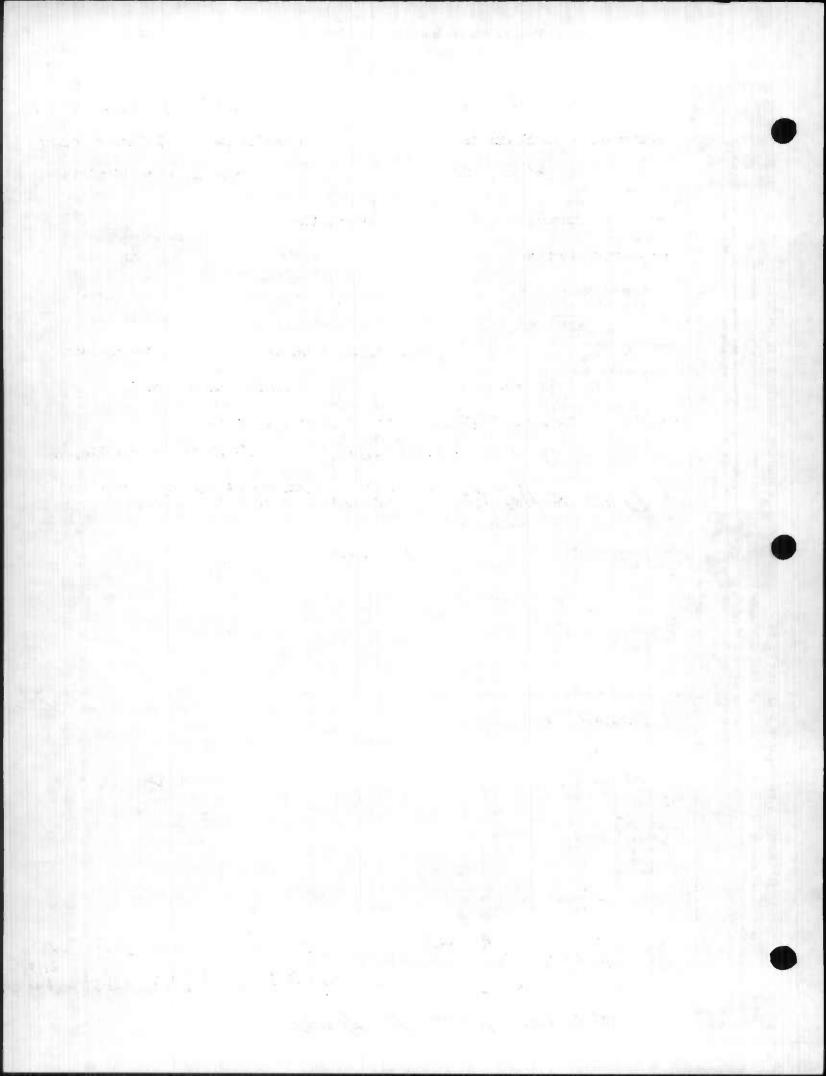
who completed cause of deeth (Item 23e) (Type, Print) 30. Neme end eddress of person MPER ITT

spow of d. Court ld. Randallstown

Registrar

MAR 0 9 2000





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month MILDRED MCGUIRE March 9, 2000 19:42 4a Feclity Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Defe of Birth (Month, Day, Year) 9. Birthplace (Ste Country)
Sept. 7, 1910 Maryland 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months 1 M 285 Yrs. 213-38-2272 89 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Ineide City Limits 1 Tyes 25000 Maryland Calvert Port Republic 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3780 Broomes Island Road 20676 United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Meritel Stetus 1 Never Merried 2 Merried Yes 2 No 1 Yes 2 No Specify: Specify: White 3⊠Widowed 4 □ Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Prince George's Co. College (1-4or 5+) Elementery/Secondery (0-12) Education School Teacher 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Charles Wesley Skinner Jessie Marian Dorsey 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20008 19a. Informent's Name/Reletionship (Type, Print) Barry Harlan Maguire (son) 3601 Connecticut Ave; NW, Apt #218, Washington, DC 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State Christ Church Cemetery 3/13/00 Port Republic, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Lee Funeral Home, Calvert, P.A. 8125 Southern MD Blvd., Owings, Maryland 20736 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enfer the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Finel Resp ament diseese or condition resulting in death) Cardine arrest Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of) assytemia Corodina Due to (or as e consequence of): Sepsis 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yee 22 No 3 Probably 4 Unknown astric ancel 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 Yes 2 No 1□ Yes 2 No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

burial-transit

physician to the burial-

signed by t

certificate

After t

Ne Hospital or Attending P n 24 hours efter death. Ne Funeral Director: After t

To the To the F

funeral

To

Box 68760,

P.0.

Records,

Division of Vitai

and

Physician

/Medical

Examiner

Funeral

Director

than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

72 hours after

I Hygiene.

permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Physien Important: if item 27 is marked other tha any Injury or other traumatic event, the DOCS.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

Examin Physician/Medical by Completed Be

Metastatic

Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Death

2 Accident

4 ☐ Homicide

(Check only one)

3 Suicide

29e. Certifier

28e. Dete of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28b. Time of 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

🖆 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier

MD

29c. License number D 50290 29d. Dete signed (Month, Day, Year) 3-10-2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Dhiren Shah, M.D. Prince Frederick, MD 20678

State Registrar

31. Dete filed (Month, Day, Year) 32. Registra/s Signature 3 2000 MAR 1

State of Maryland / Department of Health and Mental Hygiene 00 09734

	is ve street and nur							2. Date of Dea Month March	Day 6	2000	3. Time of Death 12:26AM
Ft. Washington S. Social Security Number 578-60-6267 Jauel Residence of Decedent	We street and nur Hospita		512						6	2000	12:26AM
Ft. Washington Social Security Number 578-60-6267 Jauel Residence of Decedent	Hospita Sex					41 (0): -		41			
578-60-6267 Usual Residence of Decedent								ocation of Death	,		orge's
	X.	7. Age (In yrs. la:	Se della serie	ff Under 1 Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Sept. 3	, Year) 936	9. Birthple Counti Sout	h Carolina
			Town or Lo							10	d. Inside City Limits
Maryland Prince	George's	3		Fort W		ingto	n				1 No 2 No
10e. Street and Number 902 Palmer	Road, #	ŧ6		10f. Zip (0744			10g. Chizen of N Unite	Mhat Count d Sta	•
1, Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Fo	rces? 2 🖾 No		If Yes, speci	ly Cubi	an, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	Blac	ck, White, e	tc.
			16a. Dece	dent's Usuel	Occup	ation	t of work	ina	16b. Kind of B	usiness/Indu	ustry
Elementary/Secondary (0-12) 6th		-4or 5+)	life.						N/A		
						18. Mothe					
		nter	19b. Meilii 431:	ng Address 3 - 3r	d S	and Numb	er or Rur E . E .	#304;	Wash.,	D.C.	20032
		CANA	netery, crei	matory or oth	her pla		m. 3	Date 3/9/2000			
I John T. S	lewart	111		4001	Ben	ning	Rd.,	N.E. W	ash., D	.C.	20019
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, figure 1. In the cause of conditions, for the cause (Disease or Injury that initiated events resulting in death) Last	b. Ki	Due of for a	as a consec	quence of):	e	love	New	Say d	secu	4	
Part II. Other algnificant conditions (contributing to de	eath but not result	ing in the u	nderlying ca	use giv	ren in Part I	l.	23b. Did to	obacco usa co	ntributa to	the cause of death?
								101	/aa 2□ No	3 Prob	ably 4 toknown
								24a. Was a perfor	an autopsy med?	ava	re autopsy findings ilable prior to apletion of cause eath?
		1259		176			1	1 🗆 Y	es 20Mo	10	Yes 2□ No
25. Was case referred to medical axaminer?	Hoeritat				100		of Deat	th (Check only or	ne)		
1 ☑ Yes 2 ☐ No	101	-			,	4 LI IN	ursing Ho)
1 Natural 5 Pending 2 Accident investigation	n	h, Day Year)	Injury	M 26			No	Log. Describe n	ow agary occur	. 50	
	289. Place	of Injury - At hom ng, etc. (Specify)	ne, farm, str	reet, factory,	office					ber or Rural	Route Number,
	miner: On the ba	sis of examinatio									
9b. Signature and title of certifier		0						3	29d. Date signe	d (Month, E	Day, Year)
1 /24	~	()		L) 2:	5729	5		3/7/	00	
	1. Marital Status 1. Never Married 2. Married 3. Widowed 4. Divorced 15. Decedent's E (Specify only highest or Elementary/Secondary (0-12) 5. th 7. Father's Name (First, Middle, Last James Quarl 19a. Informant's Name/Reletionship Yolanda Mathis 10a. Method of Disposition 1. Burlal 2. Cremation 3. Let Donetton 5. Other (Specify) 21. Signeture of Funerel Service Lice 22a. Part (Enter the disease, or come shock or heer feiture. List only mediate Cause (Final disease or condition esulting in death) Sequentially list conditions, and lisease or condition esulting in death) Sequentially list conditions, and lisease or condition esulting in death) Sequentially list conditions, and lisease or condition esulting in death) Sequentially list conditions, and lisease or injury hat initiated events esulting in death) Last Sequentially list conditions, and lisease or light of the conditions of the condit	1. Marital Status 1	1. Marital Status 1. Never Married 2. Married 3. X. Armed Forces? 1. Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)	1. Marital Status 1. Marital Status 1. Never Married 2. Married 3. X. Widowed 4. Divorced 1. Yes 2. Z. No. H. Yes, Give Year or Dates: 1. S. Decedent's Education (Specify only highest grade completed) [Selementary/Secondary (0-12) College (1-4or 5+) 7. Father's Name (First, Middle, Last) James Quarles [9a. Informant's Name/Reletionship (Type, Print) Yolanda Mathis — Daughter 1. Sunial 2. Cremation 3. Removal from State 4. Donetion 5. Other (Specify) 21. Signeture of Funerel Service Licensee 22. A. Party, Enter the disease, or complications that caused the death. Do not enter shock, or heert feiture. List only one cause on each line. 22. Party, Enter the disease, or complications that caused the death. Do not enter shock, or heert feiture. List only one cause on each line. 23a. Party, Enter the disease, or complications that caused the death. Do not enter shock, or heert feiture. List only one cause on each line. 25a. Party, Enter the disease, or complications that caused the death. Do not entered the cause. Enter Underlying along the conditions are shock, or heert feiture. 25a. Party, Enter the disease or conditions are conditions are southing in death) Due to (or es a consect of Licensee) 25a. Party, Enter the disease or conditions contributing to death but not resulting in the underlying and the death of Land the death of Land the cause of Land the death of Land the death of Land the Cause (Disease or Injury) 25a. Cartifier (Check only 2. Needligation and manner stated. 25b. Signature and with of certifier 25c. Cyrus Nemati, M.D. 3611	1. Marital Status 1	1. Marrial Status 1	1. Merital Status 1 Never Married Married 12. Was Decedent Ever in U.S. Armed Forces 13. Wes Decedent of Hispanic Or If Yes, specify Cuban, Merica 12. Wes Cape 14. Merital 13. Decedent of Hispanic Or If Yes, specify Cuban, Merica 14. Merital 15. Decedent's Education 15.	1. Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp. 11 Wes, specify Cuban, Marctan, Puerio I I I I I Wes, specify Cuban, Marctan, Puerio I I I I Wes, specify Cuban, Marctan, Puerio I I I I I Wes, specify Cuban, Marctan, Puerio I I I I I I I I I I I I I I I I I I I	1. Marital Status Naver Married Naver Mar	1. Marital Status New Proceder of Historic Corpin' (Specify) Yes or No-Maried Status New Proceder of Historic Corpin' (Specify) Yes or No-Maried Status New Proceder of Historic Corpin' (Specify) Yes or No-Maried Yes, Game New Proceder of Historic Corpin' (Specify) Yes or No-Maried Yes, Game New Proceder of Historic Corpin' (Specify) Yes or No-Maried Yes, Game New Proceder of Historic Corpin' (Specify) Yes or No-Maried Yes, Game New Proceder of Historic Corpin' (Specify) Yes or No-Maried Corporation of Historic Corpin' (Specify) Yes or No-Maried Corpin' (No-Maried Yes) New Proceder of Historic Corpin' (Specify) Yes or No-Maried Corpin' (No-Maried Yes) New Proceder of Historic Corpin' (No-Maried Yes) No-Maried Yes or No-Marie	1. Marital Status Name Process Name (Process Name (Process) Name

DHMH 16 Rev 6/95

State

Registrar

MAR 0 8 2000

	1. Decedent's Name (First, Middle, Last)										Reg. No.		1	_
cian										2. Date of De Month	Day	Year	3. Time of	Death
tical	PARRIS MOULTRI	-						th Oh: Ye		MARCH			2140	
iner	4a Facility Name (If not institution									cation of Deatl		ty ol Death		
	SHADEY GROVE A 5. Social Security Number	6. Sex	LIST	7. Age (In yr		hday) If U	nder 1 Year	ROCKV		8 Date of Bir		GOMERY		or Eornian
il T	248 48 6143	1⊠ M	2 🗆 F	65		rs. Mon		Hours	Min.					
	Usual Residence of Decedent			0.						00-20-	-24	PINE	ATTIE	, 50
	10s. State 10b. County			10c. (City, Town	or Location						1	0d. Inside Cit	ty Limits
tor	MD MONTO	OMERY	7		ERMA	NTOWN							1 ☑ Yes	2 No
Directo	10e. Street and Number		-11			101	. Zip Code				10g. Citizen o	f What Coun	ntry?	
	18608 MATENY F	ROAD	2087				74	74 τ			STATE	ES		
Funeral	11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?			S. 13. Wes Decedent of Hispanic Orig			in? (Spe , Puerto l	cify Yes or No Rican, etc.))- 14. R	ace - Americ		
	1 Never Married 2KMarried		1 ☐ Yes 2 ☒ No If Yes, Give			1 ☐ Yes 2 ☒ No Sk						ily: BLA		
d by	3 Widowed 4 Divorced		Year or D	etes:	100	D d Wa I								
Completed	15. Deceden (Specify only higher	st grade cor	mpleted)		16a.	(Give kind o	Usuel Occup If work done OT use retire	durina most	of worki	ng	16b. Kind of	DUSINGSS/INC	oustry	
T I	Elementary/Secondary (0-12) College (1-4or 5+) NOTICE BUS OWNER									TRANS	PORTAI	MOIT		
by Medical Department of Health and Mental it important of Health and Mental it important of them 27 is marked of any injury or other traumetic even any injury or other traumetic even and the second of the secon	17. Father's Name (First, Middle, Last) 18. Mother's Nen							r's Neme	(First, Middle	, Maiden Sumi	ame)			
	JOHN MOULTRIE							LUC:	ILLE	CANTY				
	19a. Informant's Name/Relations	hip (Type, F	Print)		19b.	Meiling Add	Iress (Street	and Numbe	r or Rura	l Route Numb	er, City or Tow	n, State, Zip	Code)	
	DOROTHY MOULTRIE WIFE SAME AS 10a., b, c, e								, e	and f.				
	20a. Method of Disposition										wn, Stete			
	1 Derial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) FORT LINCOLN 3/6/00 BRENTWOOD, MD													
	Juan Smi	ill	. 4	c#0273		3015		St., 1	NE I	WASHING	RHINES GTON, D)17	
	23 Part 1. Enter the disease, or shock, or heart leilure. List Immediate Cause (Finet disease or condition resulting in death)	complication only one ca	ons thet on ause on a	caused the desach line.	eath. Do n	3015 ot enter the	12th mode of dyir	St., 1	NE I	WASHING	GTON, D	C 200		e ween Death
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Examiner	Immediate Cause (Finet disease or condition resulting in death)	complication only one call	ons thet on ause on a	JMONIA	eth. Do n	3015 ot enter the	12th mode of dyin	St., 1	NE I	WASHING	GTON, D	C 200	Approximete Intervel Bet Onset and I	e ween Death
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o se completed by rillyaicianymedical	Immediate Cause (Finet disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant conditions are conditions or conditions.	b c d	PNEU pneu pneu pneu ating to d	Due to Due to Due to Due to	(or as a co	3015 of enter the onsequence onsequence the underlying	12th mode of dyin e of): of): of):	St., Ing, such es of	JONE I	23b. Did 1	10bacco use of Yes 2000 ormed?	contribute 1c 3 Prod	Approximete Intervel Beh Onset and II. 5 DAYS 15 DAYS 16 cause of bebly 4 allebe prior templetion of cideath?	e ween Death S of death? Unknown
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DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 7 2000

State of Maryland / Department of Health and Mental Hygiene \cup \cup Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 03 05 2000 12:25 PM MORGAN

Physician /Medical Examiner

PRINCE GEORGE'S HOSPITAL

4e Fecility Neme (If not institution, give street end number)

10b. County

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death PRINCE GEORGE'S

Funeral Director

"natural", or frame 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or itams 23a any injury or other treumatic evant, the Medical Expression mans 1.

Physician /Medical

Examiner

physician and s the burial-transit

for use as

ed by the e

signed by t

should

s certificate has t director, page 2 s

this funeral

After

death.

in 24 hours efter death.

In Funeral Director: Af

20

director

the death certificeta be axecuted

The law requires that

or Attending Physician:

the Hospital

To the

Box 68760.

o

Division of Vital Records, P.

with the Maryland

Usuel Residence of Decedent Directo 10e. Street and Number 6604 Greig Street, #101 Funeral P Completed

10

Examine

Physician/Medical

by

Completed

Be

2

Certification:

edicai

5. Sociel Security Number 1□M 2XF 577-46-5781

7. Age (In yrs. lest birthdey) 65 Yrs.

10c. City, Town or Location

If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min

8. Date of Birth (Month, Dey, December 9. Birthplece (State or Foreign 18,1934 Georgia

10d, Inside City Limits

1 Yes 2 No

10a. Stete Maryland

JUANITA

Prince George's

Seat Pleasant 10f. Zip Code

10g. Citizen of Whet Country? 20743

U.S.A.

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 N No If Yes, Give Yeer or Dates:

 Was Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Rece - American Indian. Bleck, White, etc.

Black

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementery/Secondary (0-12) 12th

House Wife

17. Fether's Neme (First, Middle, Last)

Jessie Huff

19e. intorment's Neme/Reletionship (Type, Print) Willie Morgan, Jr./Husband

Obie Fortune 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

6604 Greig Street, #101, Seat Pleasant, MD 20743

18. Mother's Neme (First, Middle, Meiden Sumeme)

20a. Method of Disposition

1 N Burlel 2 ☐ Cremetion 3 ☐ Removel trom Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, cremetory or other place) Harmony Memorial Park

20c. Location - City or Town, State 2000

Landover, Maryland

21. Signature of Funeral-Service Licenses

0

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Immediete Ceuse (Finel diseese or condition resulting in deeth)

Sequentielly list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

Due to (or es e consequence ot)

Approximete intervel Between Onset and Deeth

Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24a. Was an autopsy

25. Was case referred to medical examiner?

26. Place of Death (Check only one)

24b. Were autopsy tindings eveilable prior to completion of cause ot deeth? 1 ☐ Yes 2 ☐ No

1 Yes 25 No

Hospital: Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Pesidence 6 Other (Specify)

1 Yes

28d. Describe how injury occurred 26b. Time of Date of Injury Month, Day Year) 28c. Injury at Work? 1 Yes 2 DNo

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

27. Manner of Deeth

Neturel

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29c. License number

29b. Signature and title of certifie

ames

29d. Date signed (Month Day, Year)

0 30. Name and andress of person who completed ceuse of deeth (Item 23e) (Type, Print)

20785 Cheverly MD

State Registrar 31. Dete tiled (Month, Dey, Yeer) MAR 0 7 2000

5 Pending investigation

6 Could not be determined

Cat

avenis M.D. 32. Registrer's Signeture

3001

---- 3000 F O RAF

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** 2000 Vernon Lee //Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Doctor's Community Hospital Lanham Prince George's 9. Birthplace (State or Foreign Country)

Examiner **Funeral**

Director Directo Funeral 8 þ

Completed

Pages 1 and 2 should be nent of Health and Mental M Health a 8

Maryland

Baltimore, Physician /Medical Examiner

The law requires that the death certificate be asscuted Box 68760. the USB 85 Records, P.O. Division of Vital Juneral director, this After Attending

within 24 hours after death. To the Funeral Director: A filled in by 6 npletely \$ State Registrar

edical

If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Months Days Hours 1 M 2 □ F 230-10-9019 81 June 12, 1918 Virginia Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location Prince George's Maryland Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5215 59th Avenue 20737 U.S.A. 12, Was Decedent Ever in U,S. Armed Forces? 1 (X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Leaman Mills Ruby Maxfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Mills - Wife 5215 59th Avenue, Riverdale, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MD National Memorial Park 3/9/2000 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gasch's Funeral Home, P.A. aud 4739 Baltimore Avenue, Hyattsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Examiner tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last thers Sc lentre Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified Me ar

4 Homicide

(Check only one)

29a. Certifier

MMI

29c. License number

29d. Date signed (Month, Day, Year)

10d. inside City Limits 1 X Yes 2 ☐ No

20781

weeks

Approximate Intervat Between Onset and Death

1 Yes 2 No

White

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RASUL AMJA) 4700 BERWYN

31. Date filed (Month, Day, Year) MAR 0 9 2000 32 Registrar's Signature

3998 6 8AM

the same

State of Maryland / Department of Health and Mental Hygiene 00 09738

	Certificate of D	Death Reg. No.								
	Decedent's Neme (First, Middle, Last)	2. Date of Deeth Month Dey Y	3. Time of Death							
Physician /Medical	Brenda J. McIntyre	March 4, 2000	1910							
Examiner		c. City, Town, or Location of Deeth 4c. County of	Death							
	Malcom Grow Medical Center AAFB	amp Springs Prince	Georges							
Funeral Director	5. Social Security Number 5. Social Security Number 1 M 2 F 7. Age (In yrs. last birthdey) H Under 1 Year Months Days	Hours Min. December 13.1952	Birthplace (State or Foreign Country) Washington,							
show dat	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limit							
or 28s-1 sh be notified.	Maryland Prince Georges District Heights		1 □ Yes 2 ☑ N							
or 28a-f. De notifie Directo	10e, Street and Number 10f. Zip Code	10g. Citizen of Wh	10g. Citizen of What Country?							
S E E	7610 Kipling Parkway 20747	U.S.A.								
natural, or hams 20a Scal Examiner must.	1 Never Merried 201 Married 1 Yes 20 No H Yes, Give 1 Yes 20 No H Yes, Give Year or Detes:	, Mexican, Puerto Rican, etc.) Black,	American Indien, White, etc. Black							
ygiens. we than "naturn s, the Medical I Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16e. Decedent's Usuel Occupated (Give kind of work done do life. DO NOT use retired) Cashier	tion If the Kind of Busing most of working Retail 0								
	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)								
Mantal P Mad off Bc ever To Be	Jesse E. Zimmerman	Floree Sistare								
T is me traume	19e. Informent's Neme/Relationship (Type, Print) William McIntyre / Husband 19b. Mailing Address (Street et 7610 Kipling Pa	nd Number or Rural Route Number, City or Town, St rkway District Heights,								
it. Pages 1 and thrent of Health rank if them 27 hury or other to	20a Method of Disposition 20b, Pleca of Disposition (Neme of	Date 20c. Location - C	ity or Town, State							
	WBurial 2 □ Cremation 3 □ Removal from Stete □ Cremetory or other place	ry March 10, 2000 Brentv								
Department of the part of the	22. Name end Address of Fecility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722									
e attending physician and by for use as the buna-transit and sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initialed events Describe acute pulmonary experience of the pulmonary experience of									
0 4										
for use										
d by the setached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give B-asthma		ribute to the cause of dea 3 Probably 4 Unkn							
should should		24a. Wes an autopsy performed?	24b. Were autopsy finding eveilable prior to completion of cause of death?							
page 2		1 ☐ Yes 2(TNo	1 ☐ Yes 2 ☐ No							
certificate rector, pay	25. Was case referred to medical	26. Place of Death (Check only one)								
	examiner? 1 □ Yes 🛠 No		(Specify)							
2 m	27. Manner of Death 28a. Dete of Injury 1 kn Natural 5 □ Pending (Month, Dey Year) 28b. Time of linjury Work									
as after deam. al Director: After t led in by the funera Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)	28f. Location (Street and Number City or Town, State)	r or Rurel Route Number,							
Puner Funer stely fill dical	29e. Certifier (Check only one) 1 Nertifying Physician: To the best of my knowledge, death occurred et the time (Check only one) 1 Nertifying Physician: To the best of my knowledge, death occurred et the time (Check only one)									
To the comple	A second	29c. License number 29d. Dete signed (Month, Dey,								
To	1/h /h- D-2082	0-20827 March 6,2000								
(10)	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Glenn R. Jaucian, M.D. F.A.C.C. 9450 Pennsylv	vania Ave. #18 Upper Mar	1boro,MD 207							
Cloto	31, Dete filed (Month, Day, Year) 32. Registrer's Signature									

DHMH 16 Rev 6/95

Registrar

MAR 0 9 2000

San Marie Marie

State of Maryland / Department of Health and Mental Hygiene

00 09739

			C	ertificate of	Death		Re	g. No.		00100		
	1. Decedent's Nama (First, Middla, La	st)		111711		2. Data of Death Month		Yaar	3. Tima of Death			
Physician /Medical	Arthur Winfield	Murray					March		000	6:10 P.M.		
Examiner	4a Facility Nama (If not institution, given				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death			
	1779 Crofton Parkway Crofton							1	Arun			
Funeral Director	193 20 /324	Sex 7. Aga (In yrs	73 Yrs	Months Days		24 Hrs. Min.	8. Data of Birth (Month, Day, Dec. 10	Year)),1926		laca (Stata or Foreign try) 1Sylvania		
P 2	Usual Residence of Decedent 10a. Stata 10b. County	10c. C	ity, Town or	Location				10d. triside City Limits				
Maryla 4 short led at	Maryland Anne Ar	ındo1	rofto							1 ☐ Yas 2√∏No		
or 28e4 a be notified	10e. Street and Number	inder (,10110	10f. Zip Coda			10	g. Citizan of V	Vhat Coun	try?		
	1779 Crofton Pa			United	Stat	es						
her death there 23 inst. mast Funeral	11. Marital Status	12. Was Decedent Evar in Armed Forcas?	Decedent Evar in U,S. 13. Was Decedent of Hispanic Origin If Yas, specify Cuban, Maxican, If					14. Race	I. Race - Amarican Indian,			
5-0020 72 hours after naturals, or the fical Examina	t ☐ Nevar Married ※ Married 3 ☐ Widowed 4 ☐ Divorced	XXXYas 2 □ No If Yas, Giva Yaar or Datas: 44-		1 ☐ Yas 🏖 No			rican, aic.)	Specify	k, Whita, a Whi			
72 ho	15. Decedant's E	ducation	16a. De	cedent's Usual Occu	pation	t of worki	na 1	6b. Kind of Bu	sinass/Ind	lustry		
within see. the see. the see.	Elamantary/Secondary (0-12)	Collega (1-4or 5+)	lif	iva kind of work done a. DO NOT usa retire	ed)	TO WOLKS						
ed within led within typiens. wer than ti, the Me	12	0	Tran	sportation						irlines		
Be every	17. Fathar's Nama (First, Middla, Last William J. Murray						(First, Middle, N		a)			
To market			100 10			-	. Whiteh		0	0-4-1		
y, Maryland 21215-0020 and 2 should be filed within 72 hours at eaith and Ments! Hygiens n 27 is marked other than "satural", or er traumetic event, the Madical Exam To Be Completed by F	19a. Informant's Name/Relationship (Vera Murray	Wife	17	ailing Addrass (Stree 79 Croftor	n Park	way	Crofton	Maryla:	nd 21	114		
Sallimore, emit. Pages 1 a Apartment of Hea mportant: If Item iny Injury or othe ESS.	20a. Method of Disposition 1 Burial 2 Cramation 3 C 4 Donation 5 Other (Special	A .	Place of Di cometery, or rlingt	sposition (Nama of crematory or other pla con Nation	al Cer	rch l	5 ^{Data} 2000 ²	Arlingt	on V	wn, Stata irginia		
Demit. Department Importa	21. Signeture of Funeral Service Lice	000		22. Nama and Addr Robert E.		,	eral Ho	me, Inc				
	23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only	eller		16000 Ann	apolis	s_Rd.	Bowie	Marylan	d 20	715 Approximate		
floate be seacuted floate be seacuted so the burishinans edical Examiner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying Cause (Disease or injury that initiated events	e		sequence of):								
# 2ª ×	Due to (or as a consequence of):											
, 8 44 8V	ort II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.							23b. Did tobacco use contribute to the cause of death				
E X 0							1 Y	s 20KNo	3 Prot	oably 4 Unknown		
The law requires the law has been signed page 2 should be Completed by							24a. Was ar perform		878	ara autopsy findings allable prior to mpletion of cause death?		
The law site has page 2							1 ☐ Ya	s 2 No				
sician: The cartificate irector, par	25. Was case referred to medical				26 Place	a of Death	1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☑ No th (Check only ona)					
y state of the control of the contro	examiner? 1 Yes 25 No	Hospitel: 1 Inpatient 2	☐ ER/Outpa	tient 3 DOA O	her		ma 5 8 Reside		ar (Specify	y)		
ding Phys Atterbis Huneral d	27. Manner of Death 1 25Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Tim Injui	a of 28c. Inju		1	28d. Dascribe ho		, , ,			
LIVISION C tall or Attending P as Director: Atter ad in by the funera Certification:	3 Suicide 6 Could not b determined	28f. Location (Str City or Town		er or Rura	Routa Number,							
To the Hospital within 24 hours To the Funeral completely filled Medical C		ysician: To the best of my kn niner: On the basis of examin and mannar stated.										
To the withing To the comp	29b. Signature and little of cardina	Ew MA		29c. Licen	sa number	34	25	Mar 1	O 2	Day, Year)		
(10) Va	30. Name and eddress of person who	completed causa of death (Ite	m 23a) (Tyr	pe, Print)	c A	se	Du. (Utshi	2/20	000		
State Registrar	31. Data filed (Month, Day, Year) MAR 1 0 2000	32 Registrar's Sign		lower		1						

Education of the state of the s MAR 1.9 2000

State of Maryland / Department of Health and Mental Hygiene 09740 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month March Physician 8 2000 9:25 PM James Maksin /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7424 Taylor Street Landover Hills Prince Georges If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 10M 2□ F 66 Director 183-24-1546 July 25 1933 Pennsylvania with the Meryland permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylen. Department of Heelih and Mentel Hyglens. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show with fully or other treumstic event, the Medical Exemples must be notified at 908s. 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits VYes 2□No Directo Maryland | Prince Georges Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7424 Taylor Street

1. Marital Status

1 Never Married With Merried With Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Never Married With Merried 17 Norced 18 Yes, Give Year or Dates: Korea 20784 U.S.A. 14. Race - American Indian, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4or 5+) Nat'l Assoc.Life Under Security Guard

18. Mother's Name (First, Middle, Maiden Sumame) 0 17. Father's Name (First, Middle, Last) Paul F. Maksin Anna Adamczyk 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kathleen Carter (Daughter) 7424 Taylor St. Landover Hills, MD 20784
pe of Disposition (Name of Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) Metropolitan Crematory 3/9/2000 Alex., VA 22. Name and Address of Fecility Kendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 m, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physician and for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, P.0. 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 | Yaa 2 | No 3 | Probably 4 Unknown Division of Vital Records. ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ■ Residence 6 Other (Specify) 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 1 Naturel 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funera Certification: 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

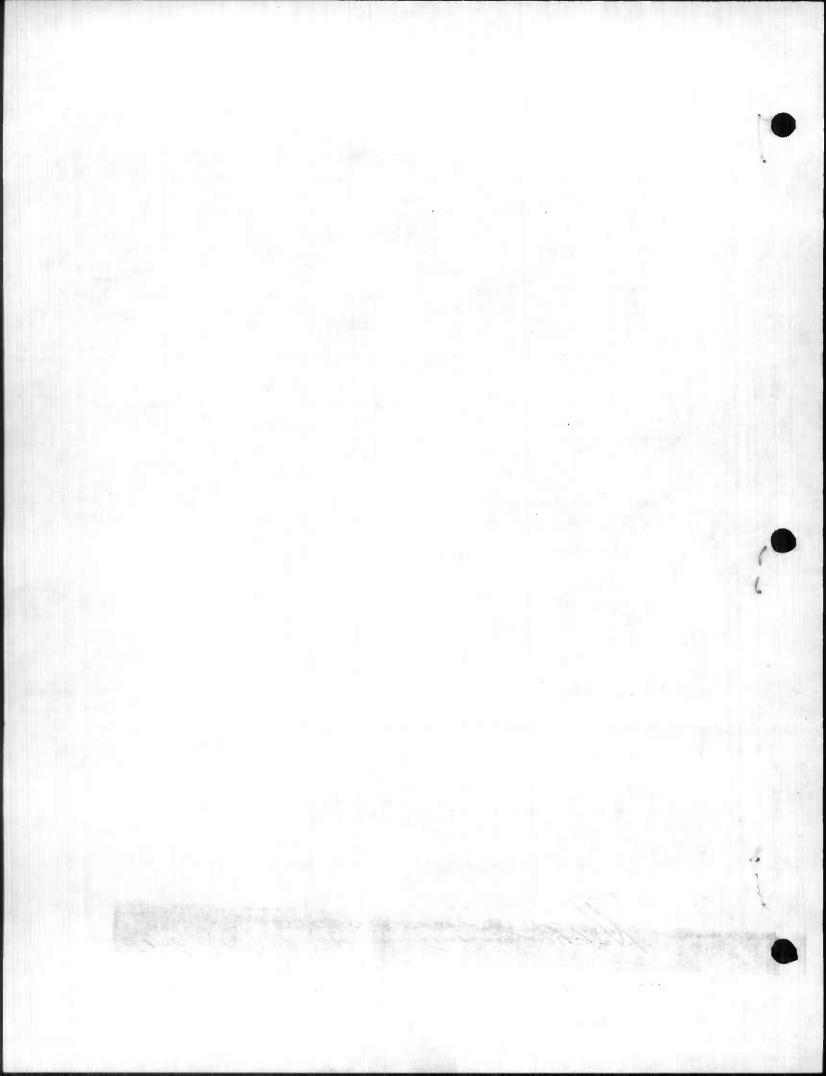
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 9, 2000 MD 30. Name and address of person who completed cause of deem (Item 23a) (Type, Print) T. Richard Lilly 5806 Baltimore Ave. Hyattsville, MD 20781 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State MAR 1 0 2000 Registrar

				Certifica	te of	Death			g. No.	UU	9/41	
Physician	1. Decedent's Name (First, Middle, La Charles Web		in				Mont		Day	Year	. Time of Death	
/Medical	4a Facility Name (If not Institution, giv					4b. City, Town, o	Mar ar Location of		1.0 200 4c. County		:00 pn	
Examiner	Stella Maris					Timoni			Bal	timor	е	
uneral rector	217-05-5501	ex X M 2□ F 8	In yrs. last bir 9	Yrs. If Und Months	er 1 Year Days		n. 8. Date (Mon NOV	of Birth th, Dey, 2.2	, 1910	9. Birthplace Country) Mary	(State or Forei	
28a-f show notified at ector	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore	Oc. City, Tow	n or Location							Inside City Limi	
a or 28a-f Lbe notifie Directo	10e. Street and Number 17026 York Ro	oad	d 101. Zip Code 21120								en of What Country?	
at, or tems 23a or 28a-1 s Exercises must be notified by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes. Give	. Was Decedent Ever In U.S. Armed Forces? 1 ☑ Yes 2 ☐ No			Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.) Specify:			Blac	14. Race - American Indian, Black, White, etc. Specify: White		
byent, me Medical Be Completed	15. Decedent's Ed (Specify only highest gra Elementery/Secondary (0-12)	ducation ide completed) College (1-4or 5+)		a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busines						tructic		
d other the event, the Be Com	17. Fether's Name (First, Middle, Last)		ne	avy ra	Tribute	nt Oper		fiddle. M		-	ti uc cic	
2 -	Harvey M. Ma						h Ski					
of Health and filter 27 is my other trauma	19a. Informant's Name/Reletionship (Nancy L. Barro					and Number or						
	Nancy L. Barrow/Daughter 8728 Stockwell Rd., Par 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nancy L. Barrow/Daughter 8728 Stockwell Rd., Par 20b. Place of Disposition (Neme of cemetery, crematory or other place) Middletown Cemetery 200								Oc. Location -			
Important: I any Injury o	23a. Part1. Emer the disease, or comshock, or heart failure. List only	sustate	e death. Do	J.J.	Har	ess of Facility tenste: nd St., ng, such as card	in Mo New	rtua Free lory arre	ary, I	Ap	proximate erval Between	
sician edical iminer	Immediate Cause (Final disease or condition resulting in death)	a		ASCULA		CCIDENT	r'			, On	set and Death	
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butal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	y list conditions, ng to immediate er Underlying asse or Injury										
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stached for use eached for use Physician/	Part II. Other eignificent conditions of	ontributing to death but r	ot resulting in	n the underlying	ceuse gi	oiven in Part I. 23b. C			Did tobacco use contribute to the cause of deat			
to detach be detach by Phy					1 🗆 Ye	8 2□ No	3 Probabi	y 42000 Nikno				
page 2 should to Completed 8								Was an perform	sutopsy ned?	24b. Were availat comple of dea	autopsy findings ble prior to stion of cause th?	
Corr								1 🗆 Ye	s 22 No	1 🗆 Ye	es 2 No	
certific rector	25. Was cose referred to medical examiner?	Hospital:			Ott	26. Place of D						
After this of funeral din tion: To	1 Yes 2 X No 27. Menner of Death A Natural 5 Pending Investigation	28a. Date of Injury (Month, Dey Y		Itpatient 3 0	28c. Inju Wo	MEX INDISHIN		-	nce 6 Oth w injury occuri			
al Director: After ad in by the funer Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	7.00 2.5.10	281. Loca City	tion (Str or Town	eet and Numb State)	er or Rural Ro	oute Number,					
y till	29a. Certifier (Check only one)	ysician: To the best of miner: On the basis of example and manner stated	a <i>m</i> ination an	o, death occurre d/or Investigation	d at the ti	me, date and pla opinion, death oc	ce, and due to	o the ca time, da	use(s) and ma te and place,	inner as state and due to the	d. ceuse(s)	
To the R complete	29b. Signature apolition of certifier	seld 1	40	2		se number 15504			d. Date signe			
141	30. Name and address of person who			(Type, Print)		1000						
// Y	Eddie Nakhud	2 M T	2200	Dec 7		7 - 7 7	m 7	ener B	onium			

ORIGINAL

MARTIN, CHARLES

DHMH 16 Rev 6/95



29b. Sign

30. Nema and address of pro-Ch/13 Snydev 31. Date filed (Month, Dey, Year) MAR 0 3

Physician

/Medical

Examiner

Funeral

Director

"natural", or flams 23a or 28a-1 show

To Be Completed by Funeral Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens.

important. If lism 27 is marked other than any injury or other traumatic event, the Mi

Physician /Medical

Examiner

	State of Maryla		t of Health and N e of Death		ene 00	09742
1. Decedent's Name (First, Middle, Last)				2. Dete of Deeth Month		3. Tima of Dee
BARBARA LEE	NICHOLS			3		0830
4e Facility Neme (If not institution, give	street and number)	11375	4b. City, Town, or L		4c. County of E	
PENINSULA REGIONA			SALISBU			OMICO
220-32-9864	7. Age (In yr	yrs. last birthday) If Under Months	1 Yeer If Under 24 Hrs. Days Hours Min.		ear)	Birthplace (State or For Country) ARYLAND
Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Location				10d. Inside City Lir
DELAWARE SUSSEX	LIGHT FILE	DELMAR				1 ☐ Yes 🏖 🖸
10e. Street and Number		101. Zip	Code	100	g. Citizen of Wha	at Country?
RT. 1 BOX 494 AA		199	940	1	U.S.A.	
11. Marital Status 1 Never Merried 2 Merried 3 Notice All Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 No Hyes, Give Yeer or Dates:	n U,S. 13. Was Decedent Yes, special 1 ☐ Yes 2	dent of Hispanic Origin? (Spirify Cuban, Mexican, Puerto	Specify Yes or No-	14. Race - /	American Indian, White, etc. WHITE
15. Decedent's Educ	cation	16a. Decedent's Usuel	al Occupation	16	6b. Kind of Busine	
(Specify only highest grade Elementary/Secondary (0-12) 1 0	e completed) College (1-4or 5+)	(Give kind of work iide. DO NOT use CHICKEN FA	rk done during most of work se retired)	rking	WN FARM	
17. Father's Name (First, Middle, Last) FRANK PHILLIPS			18. Mother's Nam ETHEL	me (First, Middle, Ma	corden Sumeme)	
19a. Informant's Name/Reletionship (Ty) JEAN MALONEY - DAUC	GHTER	RT A BOX 4		ural Route Number, C , DE 1994(ate, Zip Code)
20a. Method of Disposition 1 \(\mathbb{D}\) Burial 2 \(\subseteq\) Cremation 3 \(\mathbb{R}\) 4 \(\subseteq\) Donation 5 \(\subseteq\) Other (Specify) 21. Signature of Funeral Service License	lemoval from State	01-0	ther piece)	/5/00 DEI	LMAR, DE 05 E. MA SALISBU	ELAWARE AIN ST.
23a. Part 1. Enter the disease, or complishock, or heart feilure. List only on Immediate Cause (Finel disease or condition resulting in death)	ne cause on each line.					Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consequence of):				
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25. Was case referred to medical examiner?	1 Inpatient 2	The same of the sa	**	1	injury occurred	

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 ahould be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

DHMH 16 Rev 6/95

M116010

DME

D.O.

32. Registrer's Signature

DMG

D. O.

2000

cause of deeth (Item 23a) (Type, Print)

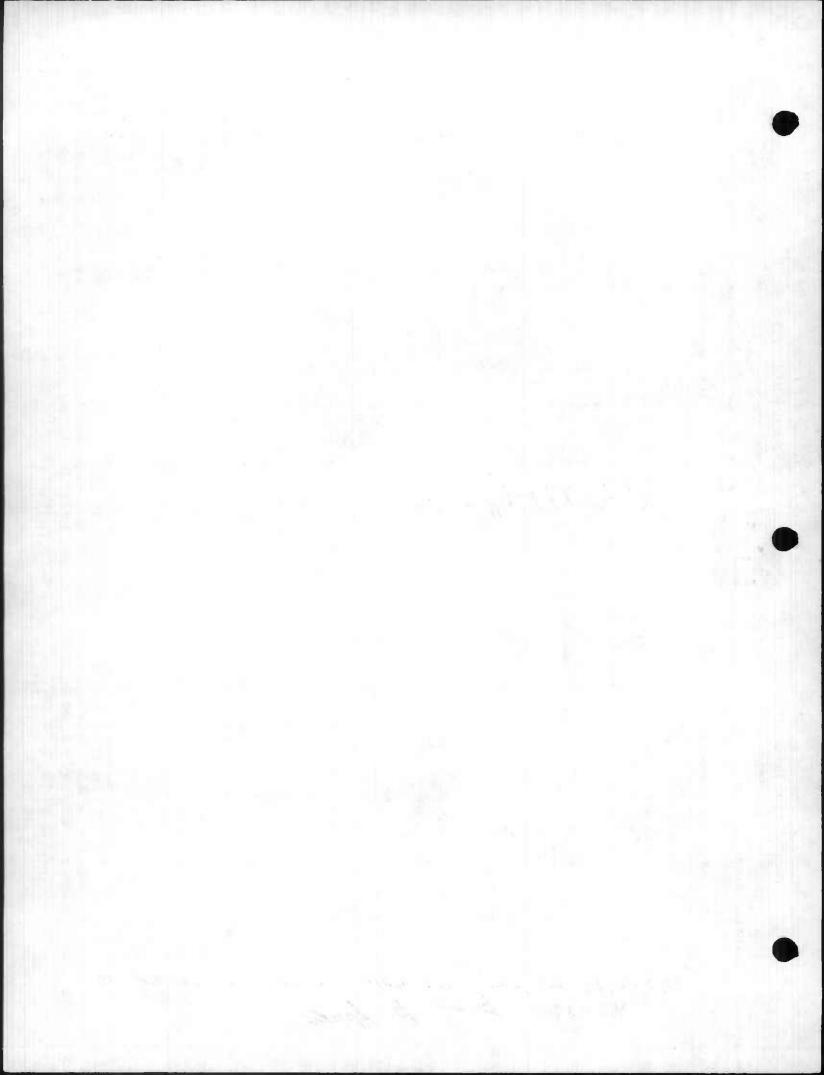
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SALISBUM, MD



ysician	1.	Decedent's Name (First, N	Aiddle, Last				imouto	of Dea	alli	2. Date of De	Reg. No. ath		3. Tima of Death	
		RUSSI			SOME					Month Marci	Day	Year .000	2:25 P	
Medical caminer	4a	Facility Name (If not Instit	tution, giva	street and nur	nber)			4b. Ci		ocation of Death	4c. County	of Death		
		Laurel		ional	Hospi		#H- 141	(= - T #)	Lau		Prince G		peorge 5	
neral ector	5	Social Security Number 578–84–4097		(M 2□ F	7. Age (In yrs. 41	last birthday) Yrs.	If Under 1 Y Months D		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da 12–6-			ace (State or Foreighty)	
12		sual Residence of Deceder la. State 10b. Co			10c. Cit	ty, Town or Loc	ation			10d. inside City Limits				
notified at rector		MD. Pri	nce Ge	eorges	12	Laurel							1 XYas 2 N	
	10	e. Street and Number			10f. Zip Code					10g. Citizen of What Country?				
our nast be		3449 Andı	cew Co	ourt #3							U.S.A.			
by Funeral	11	. Marital Status 1 Never Married 2 2 3 Status	Married	Armed Fo	2. Was Decedant Evar In U,S. Armed Forces? 1 X Yas, 2 \(\) No If Yes, Give 1 \(\) Yes 2 \(\) No				nic Origin? (Spexican, Puerto pecify:	ecify Yas or No Rican, etc.)	Specify	e - Amarica ck, White, a r: Bla	atc.	
bel	-	15. Dece	cation		16a. Deced	ent's Usuai O	ccupation		de e	16b. Kind of Bu	usiness/Ind	lustry		
of the Magnet Completed		(Specify only hi Elementery/Secondary (0-	completed) College (1	-4or 5+)	life. D	OO NOT use r	tone during retired)	g most of worl	ang					
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Be	17.	. Father's Nama (First, Mic						18.			, Maiden Suman			
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traumatic event, to	19	9a. Informant's Name/Rela									ar, City or Town,		Code)	
n end mend mend mend mend mend mend mend	20	Sandra A. No la. Method of Disposition	ewsome	MILE	20b. I	Place of Dispos	sition (Nama	of	. #302	Date	Md. 20 20c. Location -		wn, State	
		1 ☐ Burial 2 X Cremat	Burial 2 Cremation 3 Removal from State Donation 5 Othar (Specify)				cometeny crematory or other place)					Riverdale, Md.		
	21			ee /	/					3/10/00	KIVEL	uare	rici.	
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hackett's Funeral Chapel, Inc.													
		sulting in death)		1/1		or es a conseq		icse		*		~	6 ronth	
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al director, page 2 should be detached for use as the bur To Be Completed by Physician/Medical	25 27 29	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or Injury at initiated events southing in death) Last art II. Other significant conditions are incompleted in the saminer? In yes No Mapaer of Death Natural 5 Poly No Mapaer of Death Natural 5 Poly No Mapaer of Death Natural 5 Poly No Mapaer of Death Notice 6 Cc 4 Homicide 6 Cc	anditions conditions c	dospital: 28a. Date (Monitalization) 28e. Place building stotan: To the her: On the burst.	Due to (c) Due to	or as a consequence of a consequence of as a consequence of a consequ	t 3 DOA A Beet, factory, o	28. Other: Work? 1 Yes ffica	Part I. Plece of Des Nursing H 2 No	24a. Wesperful th (Check only ome 5 Res 28d. Dascribe 28f. Location City or To	Yes 20 No san eutopsyphemed? Yes 20 No one) sidence 8 Oth how injury occur (Street and Numl wm, State) cause(s) and middle end place, 29d. Data signe	24b. We avicor of the second due to ad (Month,	ere autopsy findings aliable prior to mpiation of cause death? Yes 2 No	
pletely filled in by the funeral director, page 2 should be detached for use as the bur edical Certification: To Be Completed by Physician/Medical	25 27 29	equentially list conditions, any, leading to immediate suse. Enter Underlying ause (Disease or Injury at initiated events suiting in death) Last suiting in death) Last art ii. Other significant conditions are included in the saminer? S. Was case referred to me axaminer? In yes No Mapaer of Death Natural 5 Period Conditions of the	anditions controlled the state of the state	dospital: 28a. Date (Monitorial Street Control of the building and many control of the building and t	Due to (comparison of Injury - At high etc. (Special of examiner stated.)	or as a consequence or as	t 3 DOA A Beet, factory, o	28. Other: Work? 1 Yes ffica	Part I. Plece of Des Nursing H 2 No	24a. Wesperful th (Check only ome 5 Res 28d. Dascribe 28f. Location City or To	Yes 20 No san eutopsypomed? Yes 20 No one) sidence 8 Oth how injury occur (Street and Numl wm, State) cause(s) and man dete end place,	24b. We avicor of the second due to ad (Month,	the cause of death bebly 4 Unknow ere autopsy findings aliable prior to morpiation of cause death? Yes 2 No No No No No No No No No No No No No	

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COST TRANS

Research Medical

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year 5:38 p.m. Caley Danielle O'Sullivan February 24, 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 240 Westhaven Drive Severna Park Anne Arundel H Under 24 Hrs. 8. Data of Birth (Month, Pay, Year) Sept 4, 1998 5. Social Security Number 7. Aga (In vrs. last birthday) If Under 1 Year Birthplace (State or Foraign Country) Davs 1 M 2 F Months 215-53-5887 1 Maryland Usual Rasidenca of Decedant 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits Severna Park 1 TYAS 2 XNO Anne Arundel MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 240 Westhaven Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) n/a n/a 0 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First Middle Last) Daniel O'Sullivan Stacie Peleschak 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Westhaven Drive, Severna Park, MD Daniel O'Sullivan / father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removat from Stata Schuvlkill Memorial Park 2000 Schuylkill Haven, PA 4 Donation 5 Di Other (Spec 21. Signature of Funeral Service Mi Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. MD 21146 Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentiarly list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that in the conditions) Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy of cause 1 Yes 2 The 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home SEssidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 26b. Time of 25c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Euneral

Director

28a-f show must be notified at

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Нета 23а death

if led within 72 hours after de If Hygiene. other than "natural", or hem

Pages 1 and 2 should be filed value of Health and Mental Hygie

Baltimore, Maryland 21215-0020

Director

by

Completed

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the Maryland

94 Athor Attending death. after death Director: A d in by the f

Box 68760

D'O

Records,

of Vital

Division

Medical

29e. Cartifier

Physician/Medical à Completed 89 Certification: To

25. Was case referred to medical 1□ Yes 2 No

Margner of Death P Natural 5 ☐ Pending 2 Accident 3 Suicide

investigation 6 ☐ Could not be 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signature and title

29c. License number

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) 7W16HT

31. Date filed (Month, Day, Year)

Registrar's Signatura MAR 0 3 2000

DHMH 16 Rev 6/95

To the Hospital or within 24 hours at To the Funeral Di completely filled in

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MAR 03 2000

Physicial /Medica Examine

Funeral Director

pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Montel Hyglene. Important: if Item 27 is marked other then "natural", or Items 22s or 28s-f show any injury or other treumade event, the Medical Examines must be notified at

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	State of	f Maryland		rtment tificate					giene	0 0	9745
1. Decedent's Name (First, Middle, Last	1)							2. Date of Dea	ath		3. Tima of Death
Andrew James Outt	en							Februa	rv 17,	2000	1:45 A.M.
4a Facility Name (If not institution, give	street and nun	n <i>ber)</i>						ocation of Death		y of Death	1
R. Adams Cowley Sh	nock Tr	auma Ce	nter,	UMMC		Balt	imor	e		N/A	L.
5. Social Security Number 6. Se	XM 2□F	7. Age (In yrs. I		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da)	h v. Year)	9. Birth	place (State or Foreign
222-00-9007	JAM 2LIF	16	Yrs.					10- 15-		000	Md.
Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation							10d. Inside City Limits
De. Sussex			lmar								Yes 2□No
10e. Street and Number				10f. Zip 0					10g. Citizen of	What Cour	ntry?
905 Jones Terrace					9940				USA		- 6
11. Marital Status	Armed For		5. 13. W	Vas Decede Yes, specif	ent of F fy Cub	lispanic Ori an, Mexicar	gin? (Sp	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americak, Whita,	
1) Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Give Year or De	0	1	□ Yes 2	No No	Specify:			Speci	fy: W	hite
15. Decedent's Edu (Specify only highest grad	ication le completed)		16e. Decede	kind of work	done	durina mos	t of work	ina	16b. Kind of E	Businass/In	dustry
Elementary/Secondary (0-12)	College (1-	-4or 5+)	life. D	O NOT use	retire	1)				2	
10			Stud	lent		40.55	d. Mr.		High		1
17. Father's Name (First, Middle, Last)								e (First, Middle,			
John F. Outten, S								Le A. Ma			
19a. Informant's Neme/Relationship (T)								al Route Numbe			o Code)
John F. Outten, S	r. Fath		905 ece of Dispos			rrace	, De	elmar, I			our State
20a. Method of Disposition 1 2 Burial 2 ☐ Cremetion 3 ☐ F	Removel Irom S		metery, crem	etory or oth	her ple	ce)	1		20c. Location	- City or 10	own, Stata
4 □ Donation 5 □ Other (Specify)		St.	Steph				-	2-21-00	Delma	r, De	•
21. Signature of Funeral Service Licens William M	the	att	Sh 13	E. G	une	ral H	lome,	Inc.		40	
23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that ca ne cause on ea	auned the deeth ech line.	. Do not ente	r the mode	of dyi	ng, such es	cardiac	or respiretory er	rest,		Approximate Interval Between Onset and Deeth
Immediate Cause (Finel disease or condition resulting in death)	Polyf	loral S			ic	Shock				N	3-4 Days
	Multi	ple Orga	es a consequ an Dys		ion	Synd	rome		1 400	50	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Blunt	Due to (or Trauma	as a consequ		ic	Shock	. Se	vere Ili	ver la	erati	ion 19 Days
that initiated events	c		es a consequ				•	1	WHE PA		
resulting in death) Last	with!	Hepatic	,		ier	untio	n	MEDICAL	- Chr	į	
	d	перасте	vascu	rar D.	.cor	_				1	
Part II. Other significant conditions con	ntributing to de	ath but not resu	lting in the un	derlying car	usa qi	en in Parti	lead	23b. Did 1	obacco use c	ontribute t	o the cause of death?
Previous cardiopul						ely	Trans is	10	Yes 2 No	3☐ Pro	bebly 4 Unknown
Right Rib Fracture	es, Rig	ht Pleu	ral Ef	fusio	n,	- dia		24a. Wes perlo	an autopsy med?	av cc	/are autopsy lindings vailable prior to empletion of cause death?
Left Pneumothorax,	, Porph	yria						101	res 2 🗓 No		Yes 2 No
25. Was case refarred to medical examiner?					132		of Deat	h (Check only o	ne)		
1 Yes 2 No	Hospitel: 1 Kr	-	ER/Outpatient			4LI NO		me 5 Resid			
27. Manner of Death 1 □ Natural 5 □ Pending 2 ☒ Accident investigation	28a. Dete o (Mont!) 01-29	h, Day Year)	28b. Tima ol Injury 2:45		c. Inju	yat k? Yas 2∭	140	when tr	TICK ST	d on	ssenger in k-ejected ice, over-
3 Suicide 6 Could not be detarmined	28e. Place buildin	of Injury - At hong, etc. (Specify,	me, lerm, stre	et, lactory.	office			281. Location (S City or Tox	Street and Nun	ber or Run	al Route Williams Co. I.k. Gordy Mary Land
29a. Certifier (Check only one) 1 Certifying Physical Exami	iner: On the ba	sis of axamineti					d place,	and dua to tha	cause(s) and n	nanner as :	stated.
29b. Signature and title of codditor	and menn	rer stated.		29c.	Licens	e number			29d. Dete sign	ed (Month,	Day, Year)

To the Hospital or Attending Physicien: The lew requires that the desth certificate be executed within 24 hours effect desth.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burfel-transit Division of Vital Records, P.O. Box 68760,

29b. Signature and fille of or

D55064

Sparke

February 17, 2000

30. Name and address of person who completed the a of death (Item 23a) (Type, Print)

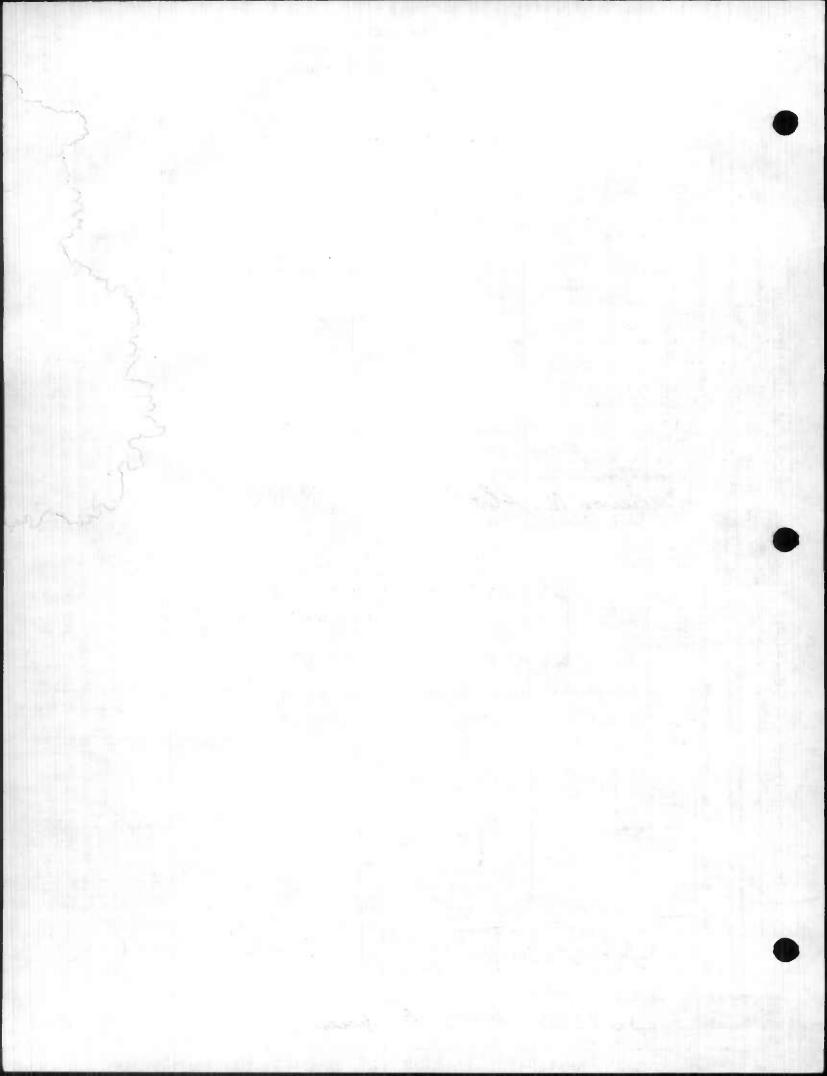
Julius D. Cheng, M.D. 22 South Greene Street, Baltimore, Maryland 21201

State Registrar

6

31. Date filed (Month, Day, Year)

32. Registrar's Signeture FFB 2 2 2000



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death March 4, 2000 Anne Month Evelyn Clifford Patrick 1540 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days 10 M 20 F Months 81 Yrs. 23, 1918 229-48-0310 Nov. Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 B & A Blvd. 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2X No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Lee Blythe Edna Purcell 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Patrick/Son 215 B & A Blvd. Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mar. 2000 Franklin, VA Poplar Springs Cem. 22. Name end Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. 21. Signature of Funeral Service Liquity Severna Park Funeral Home Severna Park, MD 21146 that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, muse on each line. Approximate Intervel Between Onset and Death nediate Cause (Final ease or condition ulting is death) PONTINE HEMORBHAGIC LARGE Due to (or as a consequence of) OBSTRUCTIVE PULMONARY DISEASE CHIBONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CARDIAC ARREST Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

Department important: If any injury or page.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f ahow

THE 23s OF

Herma 2

Director

Funeral

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Completed

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death with the Mandand

filed within 72 hours after

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i. Pages 1 and 2 should be filed w transfer of Heelth and Mantal Hygia tant: If item 27 is marked other to jury or other traumatic event, to

21215-0020

Baltlmore, Maryland

Box 68760.

P.0.

Records,

Division of Vital

8 Hospital

Examiner The law requires that the death certificate be assouted and Physician/Medical the 080 signed by the a d be detached f Completed by certificata Attending Physicien: Be Certification: To After this 24 hours after death. Funeral Director: A

25. Was case referred to medicat 1 Yes 2 No 27. Mannef of Death

1 Netural 5 Pending 2 Accident 3 Suicide 4 ☐ Homicide

investigation 6 Could not be determined

Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ST ANNAPOUS MD

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and amount certifier

00055556

29c. License number

03/05/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRIESH I. KUMAR 31. Date filed (Month, Day, Year)

MAR 0 9 2000

64 32. Registrar's Signature

FRANKLIN

State Registrar

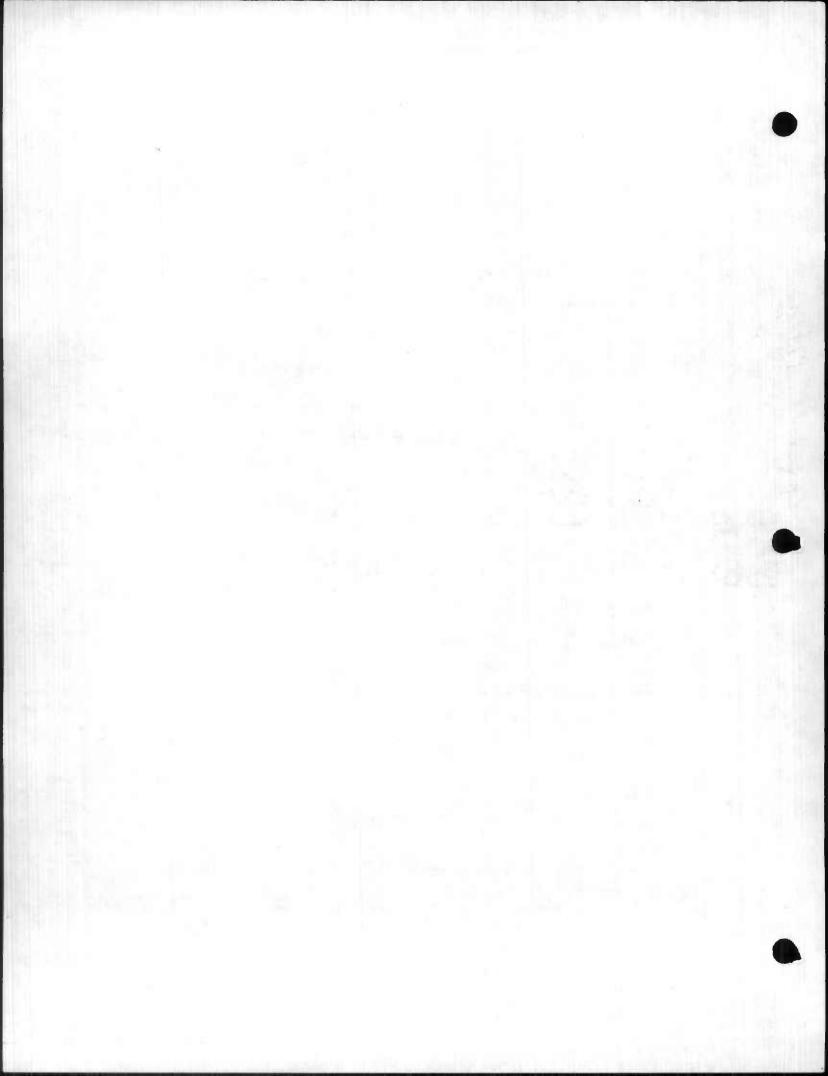
Medical

29e. Certifier

(Check only one)

within 2 4

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Price MARCH 11 Lavern 2000 4:20 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA
If Under 24 Hrs. 8.
Hours Min. CHARLES If Under 1 Year Months | Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2☑F Director February 7,37 Maryland 63 213-46-7953 the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, its Medical Examinar mast be notified at 1□Yes 2□No Directo Maryland Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 20662 8801 Oliver Place Funeral 12. Wes Decedent Ever in U,S. Armed Forcea? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. Never Married 2 Married 1 Yes ♥ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens Important: if hem 27 is marked other than any injury or other traumatic aware Elementery/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas 9 Aline E. Price James 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 8821 Oliver PLace, Nanjemoy Maryland 20662 Garry Price/ Son 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Hope CH. CEmetery 3/16/00 Nanjemoy MD 22. Name and Address of Facility ADAMS FUNERAL HOME P.A.AQUASCO MD 20608 M00191 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervel Between Onset end Death 23a, Part T. Ent **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) ISCHEMIC HEART DISEASE Examiner Due to (or as a consequence of): Examiner HYPERTENSION unknown sician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of). physician a Box 68760. certificata be Physician/Medicai Due to (or as a consequence of) 88 aftending 980 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by 1 Yss 2 No 3 Probably 4 Unknown Records. þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 Yes 2 No 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1º 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: Affer Attending 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29b. Signature end title of certifier 29c. License numbe 29d. Date signed (Month, Dey, Year) Allria U. Tayeuni D-50883 3-11-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YAHIA M.D. TAGOURI 25500 LOOKOUT ROAD LEONARDTOWN MD 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 5 2000 Depera Darks Registrar



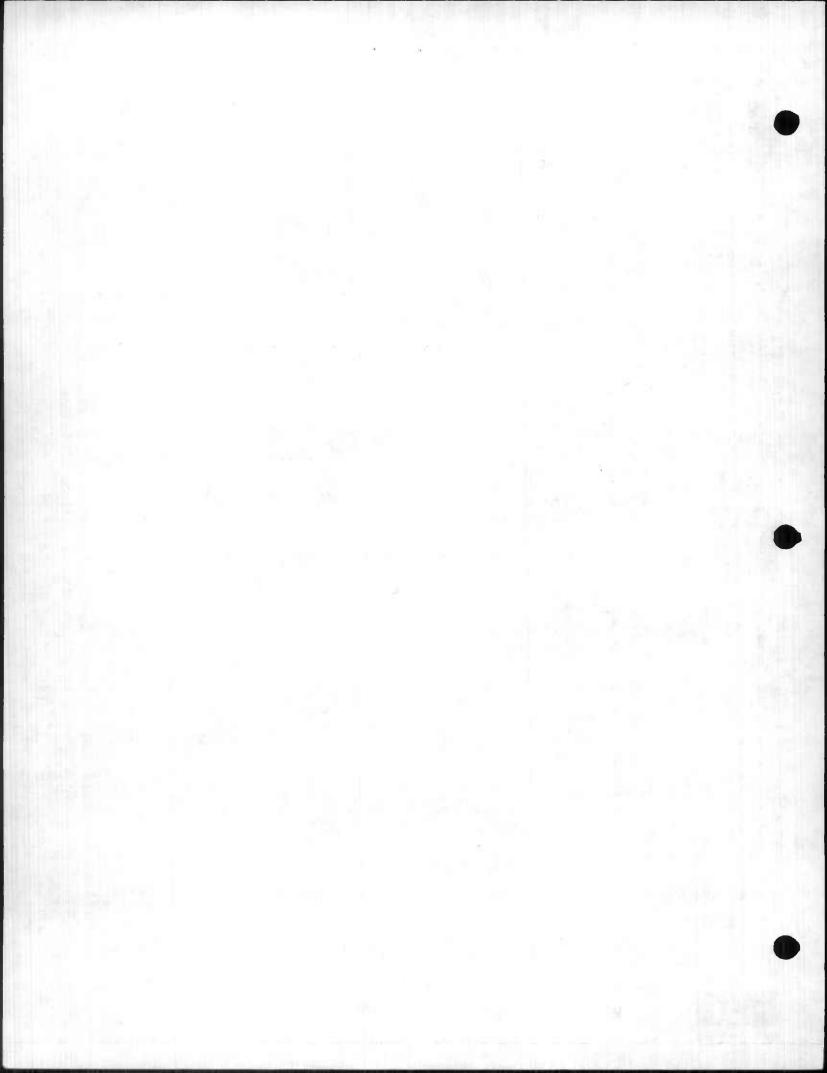
State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Day 3 **Physician** CHARLES PFETZING HENRY 2000 0900 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 110 Boston Drive BERLIN WORCESTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours M 20 F 96 Yrs. 220-24-857 Director 5-10-03 MD Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Mp. WORCESTER BERLIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 BOSTON DRIVE 21811 U.S.A. Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1./⊠Yes 2 □ No If Yes, Give Year or Detes: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. s filed within 72 hours after of Hyglens. other than "natural", or its 1 Never Merried 2 Merried Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify Specify: WHITE by 3/☑ Widowed 4 Divorced WWII Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) EDUCATION PHYSICAL EDUCATION TEAC. permit. Pages 1 and 2 should be filed v Department of Health and Mentel Hygien Important: if Itam 27 is marked other th any Injury or other traumatic avent, that page. 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be PFETZING SUSAN GOURLEY CHARLES 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 110 Boston Dr. BERLIN, MD. ESENDER 21811 SUSAN 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete LOUDEN PARK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 23a, Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ed by the attending physician and detached for use as the burlaf-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that irritated events resulting in death) Last Bue to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 1 Unknown 1 ☐ Yes 2 ☐ No been signed the det Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy s certificata has t 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be 25. Was case referred to medical 26. Place of Deeth (Check only she) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 5 Pendirig investigation 1 Natural
2 Accident 1 Yes 2 No 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 4 ☐ Homicide 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner steted. (Check only one) 29b. Signature and attle of certifier 29c. License number 29d. Date signed (Month, Day, Year) mi who completed cause of deeth (Item 23a) (Type, Print) Ave Berlin Bri 32. Pégistrer's Signeture 31. Date filed (Month, Day, Year) State

Registrar

MAR 15

2000



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 09749. Certificate of Death Amended item #26, 3/14/2000, WCHD, E.T 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 3 12 SADYE MAE CROPPER PURNELL 00 7:14 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atria Salisbury Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12/10/07 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months 1□ M 20XF Hours Yrs. 218-16-7474 92 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahos Yas 2 No MD Wicomico Director Salisbury 28a-f 2 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? b 427 Somerset Ave. 21801 USA Berns 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Raca - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 8 1 Yes 2 XNo Specify: white Specify: à 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) Postal Clerk Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill. Department of Health and Mental Hy Important: If Ilem 27 is marked oth any Injury or other treumatic even Be Granville Stokes Cropper Della Mae Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ernest Jefferson/ POA 1300 Emerson Ave. Salisbury, MD 21804 20b. Place of Disposition (Name Competery cometery, crematory or other Competery 20c. Location - City or Town, Stete 20a. Method of Disposition ©Burial 2 ☐ Cremetion 3 ☐ Removal from State Buckingham Presbyterian 3/16/00 Berlin, MD 4 Donation 5 Other (Specify) Mr of Funeral Se 22. Neme and Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 21811 16028 or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, but only one cause on each line. Approximete tnterval Between Onset and Deeth **Physician** /Medical fmmediate Cause (Final disease or condition resulting in death) Examiner Examiner lea1 emce sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Due to (or as a consequenca ot) Box 68760 physician Physician/Medical the th Due to (or as a consequence of): USB P.O. 23b. Did tobacco was contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes MINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home Presidence: 6 Nother (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 1029 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Place of Injury - At home, ferm, streef, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, or Attending Physician: 24 hours after death. filled in by Hospital

within 2 To the 12

completely

the

State Registrar

edicai

29a. Certifier

(Check only one)

29b. Signature and triggett og

Neme and address of person who completed cause of death (Item 23a) (Type, Print) Wedby 31. Dete filed (Month, Day, Year)

MAR 13

Orodula 32. Registrar's Signature

KCertifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated.

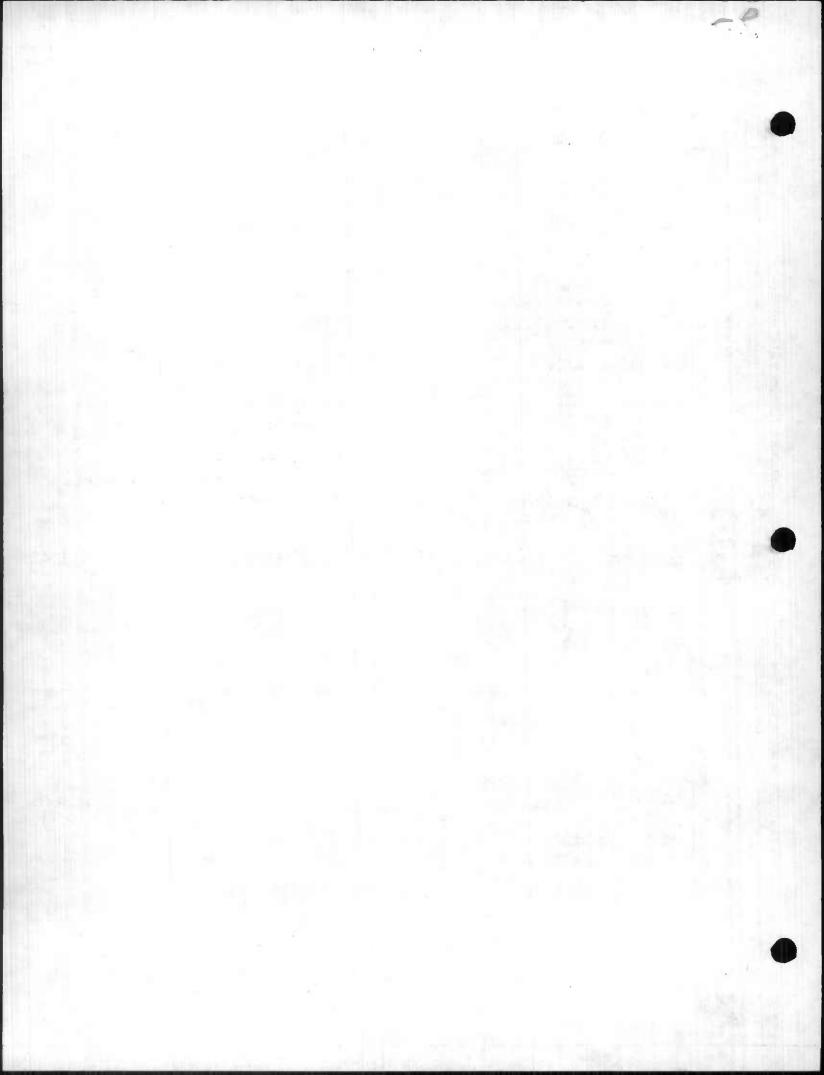
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and manner stated.

29c. License number

caluse

29d. Date signed (Month, Day, Year)

ceu



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Certificate of Death Reg. No.			
tate of Maryland / Department of Health and Mental Hygiene	00	09750.	

1 "		
		1. Deced
	Physici /Medic	R
	Examin	4a Facilit
	=	PR
	Funeral	5. Social
	Director	218

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Insurance are received in the process of theme 23a or 28a-f ahow any injury or other traumatic event, the Medical Examples must be notified at PAGE.

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

To

Physician /Medical Examiner

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit þ Completed Be Medical Certification: To

25. Was case referred to medical examiner?
1 Yes 2 No

31. Dete fited (Month, Dey, Year)
MAR 0 8 2000

27. Menner of Deeth

Neture

2 Accident

3 ☐ Sulcide

4 | Homicida

Division of Vital Records, P.O. Box 68760,

State Registrar

		State	of Ma	ryland		artmer rtificat				Mental Hy	/gier		00	09750	
1. Decedent's Nan RUTH		olle, Last) NIA PROCT	ΩR	700					Month	2. Date of Deeth Month Day MARCH 1,2000		Year	3. Time of Death 1:30pm		
4a Facility Neme	(If not institution	on, give street end n	um <i>ber)</i>						own, or L	ocation of Dea				eeth E GEORGES	
5. Social Security 218-16-		6. Sex 1 M 2 F	7. Aga	(In yrs. le	ast birthdey) 9 Yrs.	If Under Months	r 1 Year Deys	If Under Hours	Min.	8. Date of B (Month, D FEB.	av. Ye	921	Col	pplace (Stete or Foreign untry) T PLEASANT	
Usual Residence	of Decedent														
					Town or Lo		нтс							10d. Inside City Limits XXYes 2 □ No	
10e. Street and Number 5610 WALKER MILL RD				OII.	1102	10f. Zip		3					What Cor		
11. Meritel Status 1. Meritel Status 1. Meritel Status 1. Wes Decedent Ever in U, S Armed Forces? 1. □ Never Married 3. □ Widowed 4. □ Divorced 1. □ Never Married 1. □ Never Married 1. □ Never Married 1. □ Never Married 2. □ Married 1. □ Yes 2. □ No If Yes, Give Year or Dates:				S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2₺ No Specify: 14. Rece - American In Black, White, etc. Specify: BLACK					e, etc.						
	cify only high	nt's Education est grade completed	d)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Inde					industry					
Elementary/Sec 12	ondary (0-12)	College	(1-4or 5-	+)	HOMEMAKER					PRIVATE					
17. Father's Name BENJAMIN		, Last)								e (First, Middl OUEEN	e, Maio	den Surne	me)		
		ship (Type, Print) DAUGHTER									Route Number, City or Town, State, Zip Code) APITOL HEIGHTS, MD 20743				
20a. Method of Disposition 1 Thursel 2 Cremation 3 Removal from State				Ce	ace of Disponentery, cre	metory or	other ple		13	Date -9-00			GTON	Town, Stata	
21 Signature of F	uneral Service	Licego o	MIO	85		Name a AL 5538 1				PE FUN				747	
23a. Parti Enter shock, or he		complications that	í			ter the mod	de of dyl	ng, such a	s cardiac	-		-		Approximete Intervel Between Onset and Death	

disease or condition rasulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	,

1 Inpatient

28a. Dete of Injury (Month, Dey

23b. Did tobacco use contributs to the cause of death? 4 Unknown 1 ☐ Yss 2 ☐ No 3 Probably

24a. Was an autopsy performed?

1 .

24b. Were eutopsy findings available prior to completion of cause of death?

2 No

1 Yes 2□No)
26. Place of Death (Check only one)	
Other	

ER/Outpatient 3□ DOA other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Yes 2 No

28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Madical Examtner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Morgh, Day, Year) 29b. Signatury

30. Neme an Hours De

Hospital:

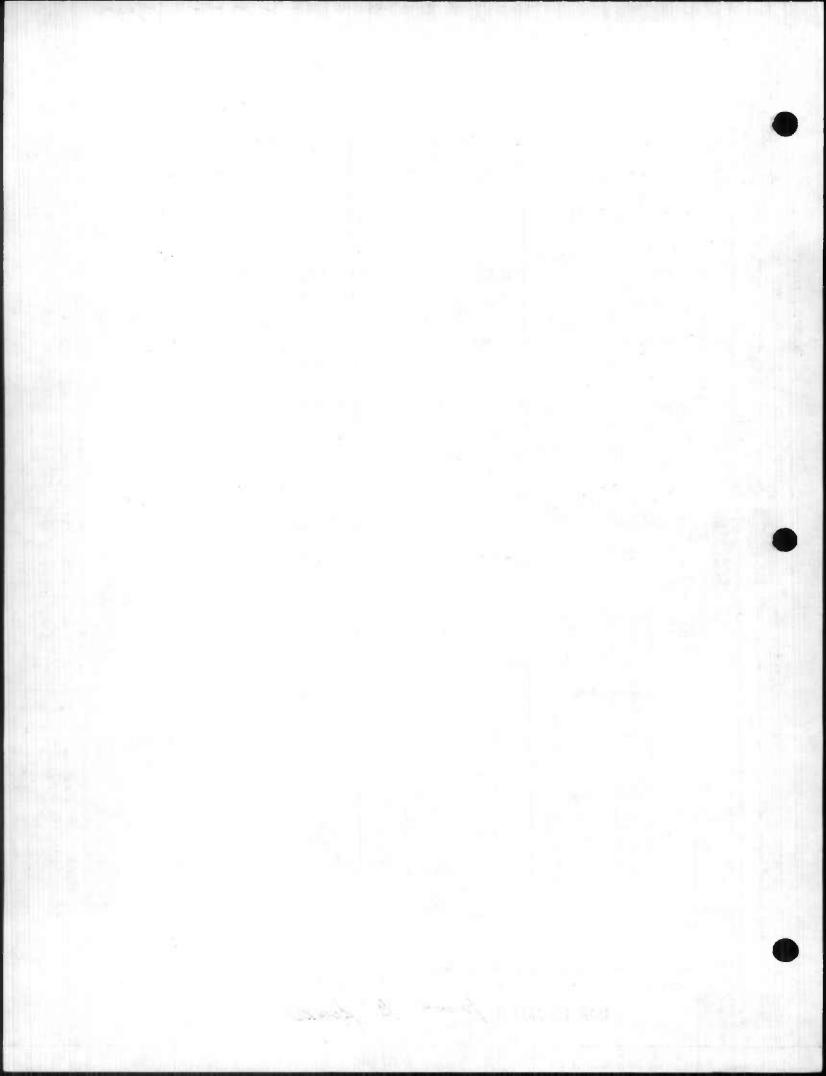
5 Pending Investigation

6 Could not be determined

32 Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene 00 09751

			Cei	rtifical	te of i	Death		Reg	. No.			O I	
edent's Neme (First, Middle, Las	st)							f Death		Venz	3. Time	of Death	
ROBINA	C.		POWELI	C,						2000	11:2	25 A.M	
cility Name (If not institution, give	street and numbe	r)			4	4b. City, Town	, or Location of I	Death	4c. Count	y of Death			
BERLIN NURSING	& REHABII	LITATI	ON						WOF	RCESTE	R		
4	Months Days Hours Mi					Hrs. 8. Defe of (Month	efe of Birth Aonth, Day, Year) 9. Birthplace (State or Foreign Country)						
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		10c. City	v. Town or Lo	ocation						11	Od inside	City I imits	
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freet and Number								100	Citizen of	What Coun		31	
	and Pd												
Maritel Status 12. Wes Decedent Ever in U													
Never Merried 2 Married	1 ☐ Yes 2 🕱 No						Puerto Rican, etc						
Widowed 4 Divorced	If Yes, Give Yeer or Detes	:		1 Ves	2 🐼 No	Specify:			Speci	y: Wh	ite		
			16a. Dece	dent's Usu	el Occup	ation	funding	16	b. Kind of E	Business/Inc	fustry		
		r 5+)	life.	DO NOT L	ise retired	1)	1.00						
12	_	Medical Transc			script	ionist		Medical					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 17. Fathar's Nema (First, Middle, Last)									dle, Maiden Sumeme)				
William Cuthbertson Jean						n Gentle	s						
19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street end Num						end Number	or Rural Route N	umber, C	City or Town	n, State, Zip	Code)	12	
cqueline Cogswe	11/Daught					e Rd.,	Liberty	, NY	1275	54			
	D. mar al form Char	^	lece of Dispo	netory or	me of other plac	ce)	Dete	20	c. Location	- City or To	wn, Stete		
		a Sal	isbury	Cre	mato	ry	3/9/0	0	Salis	bury,	MD		
gneture of Funerel Service Licen	see		22	2. Name e	nd Addre	ss of Fecility		-					
1 - 191 10					_							ation	
Pert1. Enter the disease, or com	plications that caus	MO 10	Do not en	out S	now I	HILL RO	d., Sall	Sbur	y, MD	2180		nate	
shock, or heert feilure. List only											Interval E	Setween	
diate Cause (Final				1	2		/	10		1			
se or condition	e	Ano	412.	1- (50	1 mg	1411.	C	9	6	m		
		Due to (o	r as a consec	quence of)	: (, ,				1			
	b									i			
Sequentially list conditions, Due to (or as e consequence of): if any, leeding to immediate										t			
Disease or injury	C									t			
itiated events		Dua to (or	r as a conseq	quence of):						t			
2 3 5 5 5	d									1			
										1			
Other significant conditions of	ontributing to death	but not resu	ulting in the u	inderlying	cause giv	en in Pert f.	23b.						
HUB								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown					
							240	24a. Was an autopsy 24b. Were autopsy findings					
										8V	mpletion of	or to	
										of	death?		
								1 🗆 Yes	2 X No	10	Yes 2	K No	
aminer?	Ll- a-3tal				100			-					
Yes 2 No	1 🗆 Inpa			-	OA	4th Nurs					y)(y		
	28a. Date of In (Month, D	ay Year)	28b. Time o Injury					ribe how	injury occu	urred			
Accident Investigation				М	10	Yes 2□No							
27. Menner of Death 1 Neturet 2 Accident 3 Suicide 4 Homicide 2 Homicide		28e. Place of Injury - At homa, farm, sfreef, factory, office building, etc. (Specify)						281. Location (Street and Number or Rural Route Number, City or Town, Steta)					
Homicide													
_ Homicide				h occurred	et the tin		place, and due to		se(s) and n				
Pertifier 1 Certifying Phy	yeician: To the bes					death anining	occurred at the	ima date				o/e)	
_ Homicide		of examinet				pinion, death	occurred at the t	ime, date				e(s)	
Certifier 1 Certifying Physics Check only 2 Medical Exam	iner: On the basis	of examinet		vestigation	n, in my o	pinion, death	occurred at the t		and place	e, and due to	Day, Year		
Certifier 1 T Certifying Phy Check only 2 Medical Example	iner: On the basis	of examinet		vestigation	n, in my o	e number	occurred at the t		and place	e, and due to	Day, Year		
Certifier 1 T Certifying Phy Check only 2 Medical Example	iner: On the basis and menner i	of examinet	tion and/or in	vestigation 29	n, in my o	e number	occurred at the t		and place	, and due to	Day, Year		
Certifier 1 Certifying Physics Check only 2 Medical Example ignature and fittle of certifier	completed cause of	of examinet steled.	1 23a) (Type,	29 Print)	n, in my o	e number	occurred at the t	290	and place	e, and due to sed (Month,	Day, Year		
	ROBINA acility Name (If not institution, give BERLIN NURSING clai Security Number 2-30-9813 Residence of Decedent Stela 10b. County Cyland Wicomic Streef and Number 0881 Old Fruitl aritel Status Never Merried Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra mentary/Secondery (0-12) Informant's Nema (First, Middle, Last) William Cuthber Informant's Neme/Reletionship (Informant's Neme/	Collity Name (If not institution, give street and number Collity Numbe	ROBINA C. Inclitity Name (If not institution, give street and number) BERLIN NURSING & REHABILITATI Cital Security Number 6. Sex 1 M 2 M F 80 Residence of Decedent Stela 10b. County Wicomico Street and Number 0881 Old Fruitland Rd arritel Status Never Merried Widowed 4 Divorced 11. Wes Decedent Ever in U. Armed Forcas? 1 Meyes 2 M No Widowed 4 Divorced Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Informant's Nema (First, Middle, Last) William Cuthbertson Informant's Neme/Reletionship (Type, Print) Coqueline Cogswell/Daughter Method of Disposition Buriel 2 Cramation 3 Removal from Stata Donation 5 Other (Specify) Ignelare of Funerel Service Licensee Pert1. Enter the disease, or complicetions that caused the deel shock, or heert feilure. List only one cause on each line. Informantication of the complete of the completed of the complete of the com	ROBINA C. POWEL: College (If not institution, give street and number) BERLIN NURSING & REHABILITATION Call Security Number 2-30-9813 Residence of Decedent College (In yrs. last birthday) Residence of Decedent In yrs. last birthday Residence of Decedent College (In yrs. last birthday) Residence of Decedent Residence of Decedent College (In yrs. last birthday) Residence of Decedent Residen	ROBINA C. POWELL collisty Name (if not institution, give street and number) BERLIN NURSING & REHABILITATION cital Security Number	ROBINA C. POWELL Accility Name (If not institution, give street and number) BERLIN NURSING & REHABILITATION Jail Security Number 6. Sex 2—30—9813 10	ROBINA C. POWELL cellity Name (if not institution, give street and number) BERLIN NURSING & REHABILITATION BERLIN Months Burden Leading Hunder Subject Su	ROBINA C. POWELL MARK Calley Name (if not institution, give street and number) BERLIN NURSING & REHABILITATION BERLIN NURSING & REHABILITATION BERLIN OUR STATE of the street and number) 2-30-9813 Residence of Decedent State 10b, County Wicomico Salisbury 10c. City, Town or Location Months Days Hours Min. Robert Residence of Decedent Salisbury 10c. City, Town or Location Salisbury 10c. City, Town or Location Months Days Hours Win. Robert 10c. City, Town or Location Months Days Hours Alt In June 1 In June 10c. City, Town or Location Salisbury 10c. Zip Code 21804 21804 21804 11 Yes, Specify Clash, Mexican, Poent Rican, etc. 120 No. Specify Clash, Mexican, Poent Rican, etc. 11 Yes, Specify Clash, Mexican, Poent Rican, etc. 120 No. Specify Clash, Mexican, Poent Rican, etc. 121 New Decedent Clash, etc. 122 No. Specify Clash,	2 Dies of Deach Month MARCH NORSING & REHABILITATION Service of Deach Month MARCH Service of Deach Market Service of Deach Month MARCH Service of Service of Service of Service of Deach Month MARCH Service of S	ROBINA ROBINA C. POWELL 4b. City, Town, or Location of Death MARCH 08, REHABILITATION BERLIN BOY BOY BOY BOY BOY BOY BOY BO	ROBINA C. POWELL Ab. City, Town, or Location of Death ARCH Ab. City, Town, or Location of Death Ab. City, Town, or Location BERLIN BERLIN WINDER 1020 F Committee Comm		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 09752. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death March 9th 2000 1:45 pm Frederick 4a Facility Name (If not institution, give street and number) Poole 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Sallsbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 M 2 □ F Yrs. 705-12-1749 81 October 15, 1918 Mt. Airey, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 Ellegood Street 21801 USA 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 No If Yes, Give Year or Datas: 1 Nevar Married 2 Married Army 1 ☐ Yes XX No Specify: Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Motel Manager Motel 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clarence Poole Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor K. Klaverweiden/Daughter 31812 Johnson Road, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State Salisbury Crematory 3/10/2000 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licer 22. Name and Address of Facility. Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, MD 21804 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final diseesa or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2NNo 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerformed? neumonia Essenlea 1 ☐ Yes 2 X No

Physician /Medical Examiner

Peges 1 and 2 should be nent of Heelth and Mental

permit. Peges 1 and 2 Department of Heelth a important: If Item 27 is any injury or other trai phos.

Physician

/Medical

Examiner

Directo

Funeral

Completed

Be

2

Funeral

Director

I7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examiner must be notified at

physician a signed by the aid to be detached for The law requires certificate or Attending Physician: this

P.O. Box 68760,

Records,

Division of Vital

Examiner Affer death. Director:

Physician/Medical ρλ

Completed Be Certification: To

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

State Registrar

filled in 24 hours

within 2 \$

Medical

29b. Signature and title of certifier

28a. Data of Injury (Month, Day Year)

29c. License number

D29505

28c. Injury at Work?

1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify)

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28d. Describe how injury occurred

150 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

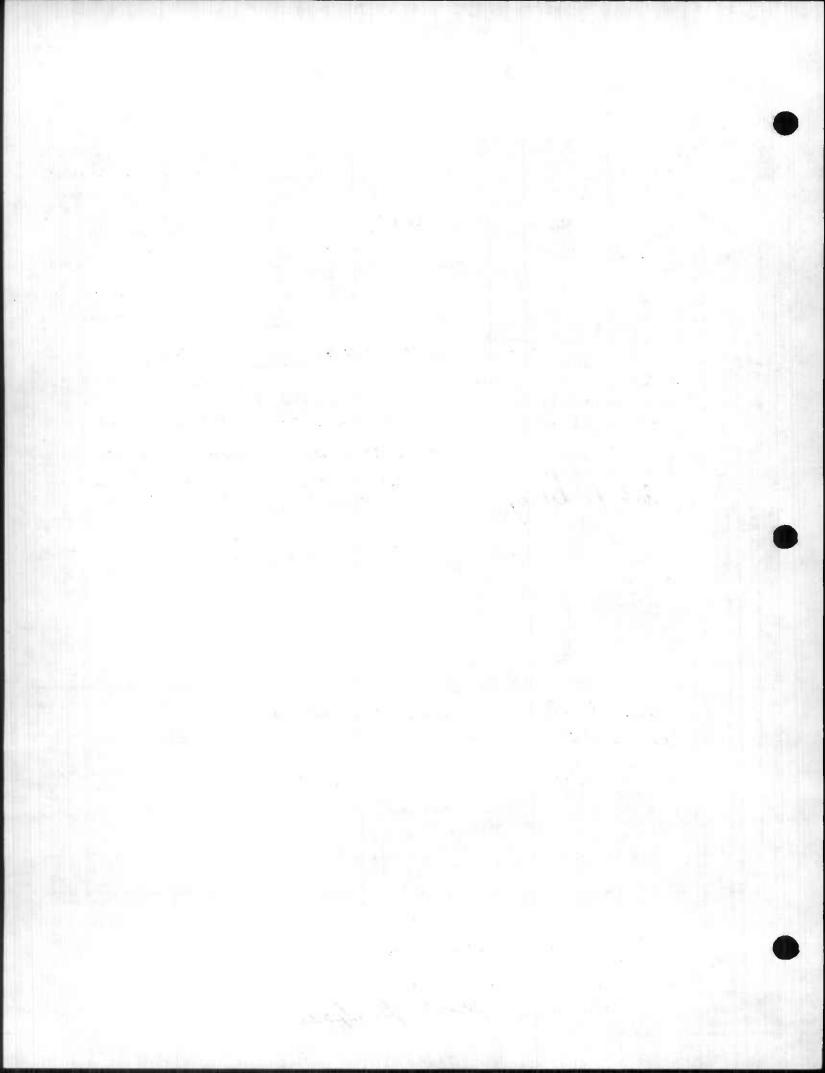
regerio love 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Gregorio Belloso 5302 Chinaberry Drive Salisbury MD 21801

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 0

28b. Tima of

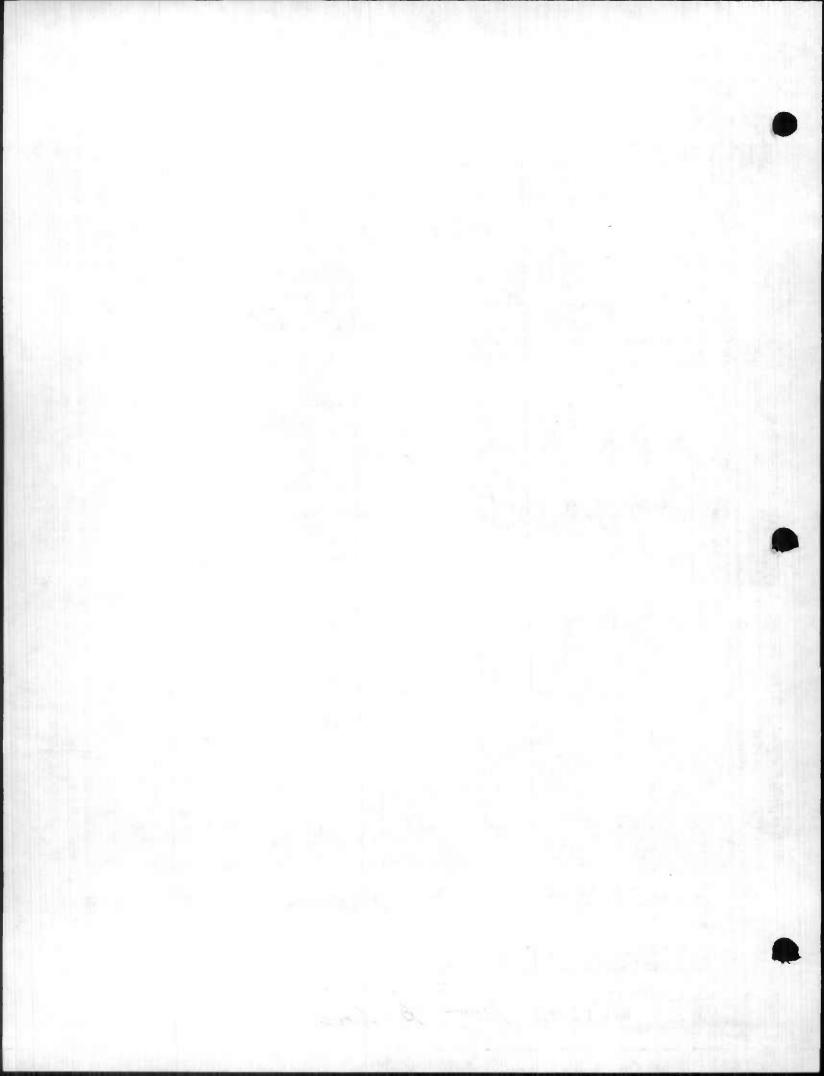
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene 0 0 9 7 5 3

200					Cer	tificat	e of	Death		Reg. No.	0	2733
Physician	Decedent's Neme (First	st, Middle, Las	st)						2. Date of Dea Month	Day	Year	3. Time of Death
/Medical	GERALDINE I								MARCH	8, 200		11:50AM
Examiner	4a Facility Name (If not in							4b. City, Town, or I		,		
	Salisbury Co			Elder		If Under		Salisbury		Wicom		lane (Chate or Francisco
neral ector	5. Social Security Numbe 221-60-077	1 1	ex □M X □F	65	Yrs.	Months	Days		8. Dete of Birt (Month, Da) 3-15-1	v, Year)	9. Birthpi Coun	Md .
6)	Usuel Residence of Dece	County		10c. City	, Town or Lo	cation					10	0d. Inside City Limits
Funeral Director		icomic	0	Del								1 Yes 2 No
Director	10e. Street and Number		US LITTLE			10f. Zip				10g. Citizen of V	Vhat Coun	try?
la l	872 Mar-Ly	nn Dr.					218			USA		
by Funeral	11. Meritel Stetus 10X Never Married 2 3 Widowed 4 D		12. Wes Decede Armed Force 1 Tes 2 If Yes, Give Yeer or Data	XNo				Hispanic Origin? (Span, Mexican, Puerl	pecify Yes or No o Rican, etc.)	Specify	e - America k, Whita, (
eted	15. D (Specify on	Decedent's Ed	lucation de completed)		16a. Deced	lent's Usu	el Occu	pation during most of wor	king	16b. Kind of Bu	siness/Ind	Justry
Be Completed	Elamantary/Secondery		Cottege (1-4	or 5+)					,	none		
8	6 17. Father's Neme (First,	Middle Last			neve	er em	Ьτο2	18. Mother's Nen	no (First Middle		a)	
	Roger Pars								Matthews		,	
10	19e. Informent's Neme/R		Type, Print)		19h Maitin	n Addraes	(Stree	t and Number or Ru				Code)
	Wayne T. P			r				Dr. Delm			_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	20a. Method of Dispositio	n		20b. Pi	lece of Dispo	sition (Ner	ne of		Data	20c. Location -	City or To	wn, State
	1 ☑ Burial 2 ☐ Cred 4 ☐ Donetion 5 ☐ C			10	Steph				3-13-00	Delmar	, De.	
	21. Signeture of Funerel 23a. Pent1. Enter the dis- shock, or heert fellu	î W.	Hort	sad the deeth	5	Short	Fur	ess of Fecility neral Homove St. D ing, such as cardiac	elmar. D	e. 1994 rest.	0	Approximata Intervat Between Onset and Death
edical Examiner	Immediate Cause (Finel disease or condition resulting in daeth) Sequentially list condition if any, leeding to immediate.	ns, ele	o. Mrs.	Due to (or	es e consequence de la consequence della consequ	uence of):	25	UNKNO - CANO	WA Pro	gruspy	>2	Syppes
Physician/Medical E	Sequentially list condition if any, leeding to immedia cause. Enter Underlying Cause (Disaese or Injury that initialed events resulting in death) Lest	1	d	Due to (or	es e consequ	uence of):						
7515	Pert II. Other significant	conditions co	ontributing to death	but not resu	ilting In the ur	nderlying o	ause gi	iven in Pert I.	23b. Dld 1	obacco use cor	ntribute to	the cause of death?
Dy 1.11	-								10	Yes 2 Tho	3 Prot	bebly 4 Unknown
2000						1			24a. Wes perfo	an autopsy med?	avi	era autopsy findings silable prior to mpletion of cause death?
Completed									10	res 20 No	10	Yes 22 No
Be C	25. Was case referred to	medical						26. Place of Dea	ath (Check only o	ne)	1	•
2	examiner? 1 Ves 2 No 27. Menner of Deeth Neturel 5 C 2 Accident	Pending Investigation			ER/Outpetien 28b. Time of Injury		8c. Inju		lome 5 Resident	dence 6 Oth		y)
Certification:		Could not be determined	286. Place of	Injury - At ho etc. (Specify	me, ferm, stri	eet, fector	y, office		28f. Location (S City or Ton	Street and Numb vn, State)	er or Rura	il Route Number,
edical	29a. Certifier (Check only one)	Certifying Phy Redical Exam	ysician: To the be siner: On the basis end menner	of examineti	vledge, deeth ion end/or inv	occurred	at the t	ime, date and place opinion, death occu	, end due to the rred et the time,	cause(s) and ma date and place,	nner as st and due to	tated. o the cause(s)
Medica	295. Signature and title d	phrtifiar				29	c. Licen	se number		29d. Date signer	(Month,	Day, Year)
	1 /6	11	10				D398	313		3/2	120	ממש
A.	30. Name and address of	person who d	completed cause of	of deeth (Item	23a) (Type, I	Print)				7	-	
3	MICHAEL AT						SAI	TSBURY.	MD 2180	14		
State	31. Date filed (Month, Day	y, Year)	32. Regi	strer's Signat				7000(1/_		*		
qistrar	MAR	1 0 200	10 100	news	19	1		1.				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) **Physician** GRACE EVELYN POHLMANN 4b. City, Town, or Location of Deeth 4c. County of Deeth /Medical 4e. Fecility Neme (If not institution, give street and number) Examiner Manokin Manor If Under 1 Ye 7. Age (In yrs. last birthdey) **Funeral** 1□ M 2X F 578-62-6705 Director 96 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location ns 23a or 28a-f s Director MARYLAND SOMERSET

ear	rince If Under	24 Hrs.	8. Dete	of Birth		9	. Birthpiece	State or	Foreign
eys	Hours	Min.			Yeer) 1903		Country) SHING		

Reg. No.

Day

Yeer

Bieck, White, atc.

SUITLAND, MARYLAND

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

4c. County of Deeth

2. Dete of Deeth

Month

1 Yes 2 No PRINCESS ANNE 10f. Zip Code 10g. Citizen of What Country? 21853 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien

WHITE 16a. Dacedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry

HOMEMAKER OWN HOME 18. Mother's Neme (First, Middle, Maiden Sumeme) LILLIAN F. VERNON

19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT POHLMANN, JR. - SON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

8116 PINTAIL DR PARSONSBURG, MD 21849 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State

4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 21. Signeture of Funerei Service Licensee

12. Wes Decedent Ever In U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yas, Giva

Year or Dates:

Cottaga (1-4or 5+)

705 E. MAIN ST. 22. Name end Address of Fecility

3/3/00

BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heer feilure. List only one ceuse on each line.

Immediate Causa (Final diseese or condition rasulting in deeth)

10e. Street end Number

11. Maritel Status

Funeral

by

Completed

Be

2

Examiner

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

GUY

If is marked other than "natural", or items traumatic event, the Medical Examiner management

11974 EDGEHILL TERRACE

15. Decedant's Education (Specify only highest grade completed)

HUNT

1 ☐ Never Merried 2 ☐ Merried

3 ☑ Widowed 4 ☐ Divorced

Eiamentary/Secondary (0-12)

Ε.

17. Fathar's Name (First, Middle, Last)

Que to (or as a consequanca of):

1 Yes 2 No Specify:

Approximete Intervei Batween Onsat and Death

24b. Were eutopsy findings evsileble prior to completion of cause of daath?

1 ☐ Yes 2 No

3. Time of Daeth

7:30 Pm

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that let it and assets. thet initieted events resulting in death) Last

25. Was case refarred to medical exeminer?

29b. Signature and title of ceqifier

2 No

1 Yes

27. Mannar of Deeth

2 Accidant

3 Suicide

4 Homicide

1 Natural

Due to (or es e consequence of):

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

24e. Wes en eutopsy performed?

28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

6 Could not be determined 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated. (Check only one)

29d. Dete signed (Month, Day, Year) 2-28-2000

me and advance of parson who complated cause of daeth (Item 23e) (Type, Print)

GREGORIO M. BELLOSO, MP 5302 CHINABERRY DR., SALISBURY, MP 2180) 31. Dete filed (Month, Day, Year)

State Registrar

FEB 2 9 2000

5 Panding Investigation

32. Registrar's Signetura

DHMH 16 Rev 6/95

after death.

within 24 hours a
To the Funeral C

filled in by the

permit. Peges 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If Item 27 is merked other than 'netu any Injury or other traumatic event altimore,

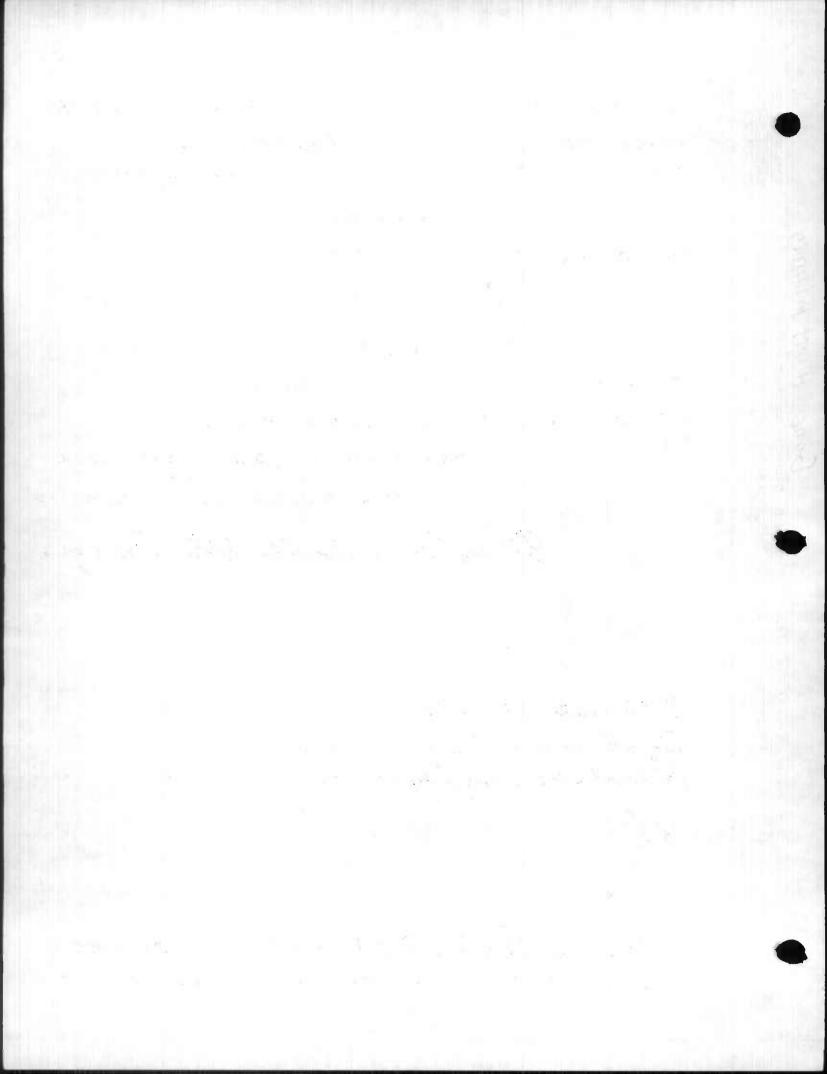
Physician /Medicai Examiner

The law requires that the death certificate be executed the burief-tran P.O. Box 68760. USB BS 0 should be deteched signed by peen certificate Hospital or Attending Physician: this After

Records, of Vital

Division

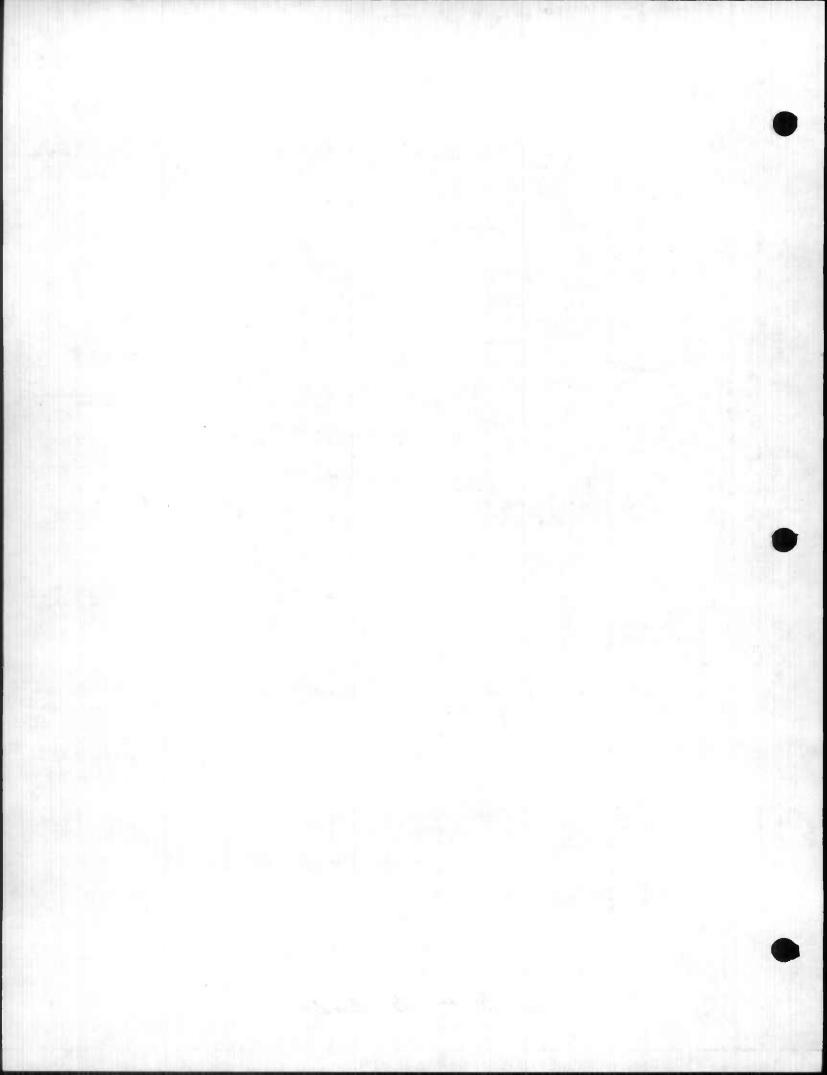
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 29, 2000 FEB. 4:55 PM JOHN HERMAN PERDUE JR /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Salisbury Center; Genesis ElderCare Salisbury, Md. Wicomico If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days 1 ₪ M 2 □ F Yrs. 85 Director 213-01-7510 March 5,1914 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Madigal Examiner must be notified at 1√ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 704 McBriety Circle 21801 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married 1 Tyes 2 No
If Yes, Give
Year or Dates: WW II Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental hyglent Important: if tem 27 le marked other tha eny Injury or other traumatic avent, that 12 4 Accountant Accounting 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 8 John Herman Perdue Sr. Mae Truitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 704 McBriety Circle, Salisbury, MD 21804 Alexandra C. Perdue/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 3/4/00 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licenses 22. Name and Address of Facility M01051 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Mampoor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphace, or heart feiture. List only one cause on each line. Approximate Interval Between Onsei and Death **Physician** multiple Strobes /Medical Immediate Cause (Final Sugges disease or condition resulting in death) Examine Examiner physician and s the burial-transit The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Leventer A signed b Records. 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: or Attending Natural 5 Pending investigation To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie on lle OC D-39813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804 31. Date filed (Month, Day, Year) MAR 03 32. Registrar's Signature State 2000

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene

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						Ce	tificate o	f Death		Reg.	No.		
Dhuo	leien	Decedent's Nar	me (First, Middla, I	Last)					2. Date	of Death	Dav	Year	3. Time of Death
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	niner	4e. Facility Name						4b City, Town	n, or Location o	Deeth	4c. County	of Death	
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Funer	ai	5. Social Security	Number 6	Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea			of Birth oth, Day, Ye		9. Births	place (State or Foraign
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yland Man		10a. State	10b. County		10c. Ci	ty, Town or Lo	cation					1	Od. Inside City Limits
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21215-0020 d within 72 hours effer giene. r than "natural", or he	by F		4 □ Divorced	If Yes, Gi	ve Nav	v	Yes 2 XN	o Specify:			Specif	. Whi	te
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of Healt of Healt fitem 2		20e. Method of Dis			20b. F	Place of Dispo	sition (Nama of natory or other p	Jaca)	Date	20c	. Location	City or To	own, Stete
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ortan Injury	4	21. Signature of F		**	AAT		. Name and Add		2/26/2	2000	Salis	bury	, MD
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Physicia	n												Onset and Death
/Medica		Immediate Cause disease or conditi	(Final	(ext	Trine	elexa	Ri C	- Lin	7/211	00,5	Di	ار مدهاه	5 gps
Examine	er	resulting in death)		a. 0000	Due to (or as a consec	neuce of):		- more				11/1
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e de	ya je	Part II. Other signi	ficant conditions	contributing to de	eath but not res	ulting in the u	derlying cause	given in Part i.	23	Did tobac	co use co	ntribute to	the cause of death?
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를 등 F	Certification:	+LI Homicide		buildi	ng, etc. (Specif	y)			City	or Town, Si	rara)		
hours meral y tille		29a. Certifier	1 Certifying P	hysician: To the	best of my kno	wiedoe, death	occurred at the	time, date and	place and due	to the cause	e(s) and ma	nner as s	teteri
Exce	edical	(Check only one)	2☐ Medicai Ext	iminer: On the ba	asis of exemina	tion and/or Inv	estigetion, In my	opinion, deeth	occurred et the	time, date	and place,	and due to	the cause(s)
within 2 To the comple	Me	29b. SignatuyoPano	title of certifier	1	ioi states.		20c Lice	nse number		204	Date slane	d /Month	Day Voorl
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100		30. Name and add	ess of person who	completed caus	e of death (Iten	1 23a) (Type,	Print)					-	
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	state	31. Date filed (Mor	TERV. Year		eeistrar's Signa	ture 4	1					,	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** WILLIAM WESLEY PRETTYMAN, JR. 8 March 2000 8:18 AM /Medical 4c. County of Death 4a Facility Name (ff not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis ElderCare -The Pines Easton Talbot If Under 1 Veer 5. Social Security Number 6. Sex XXM 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Yrs. 214-32-7043 89 AUG. 7, 1910 MARYLAND Usual Residence of Decedent 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits MD TALBOT EASTON YYes 2 No Director 10e Street and Number 10f Zin Code 10g, Citizen of What Country? 108 NORTH HIGGINS ST. 21601 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 20000
If Yas, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ŽÍXNo Specify: Specify: WHITE þ 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) -0-Elementary/Secondary (0-12) POULTRY HAULER AGRICULTURE 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First Middle, Last) Be WILLIAM W. PRETTYMAN, SR. EMMA ALDEN SIGMAN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) WILLIAM PRETTYMAN, III 20915 DOVER BRIDGE ROAD, PRESTON, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State SPRING HILL CEMETERY 3-11-00 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEHYDRATION

Due to (or sis e consequence of): Examiner CORONARY ARTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last QUE MON AR OB STRUCTIVE ARONIC Physician/Medical Due to (or as a consequence of) d.STATUS CEREBRAL VASCYLAR Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? 3 Probably 4 d Unknown 1 | Yea 2 | No à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 2 3 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the basis of any knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of oximination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated. 29a. Certifier edical

Box 68760. P.O. Records, Division of Vital Hospital or Attending Physician: s after death. within 24 hours a To the Funeral C

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours ahar ment of Health and Mental Hygiene.

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/Medical

Examiner

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page 2

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altimore, Maryland 21215-0020

State Registrar

29b. Signature and title of country

DANIEL

31. Dete filed (Month, Day, Year)

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MAKAS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAKAS.

2000

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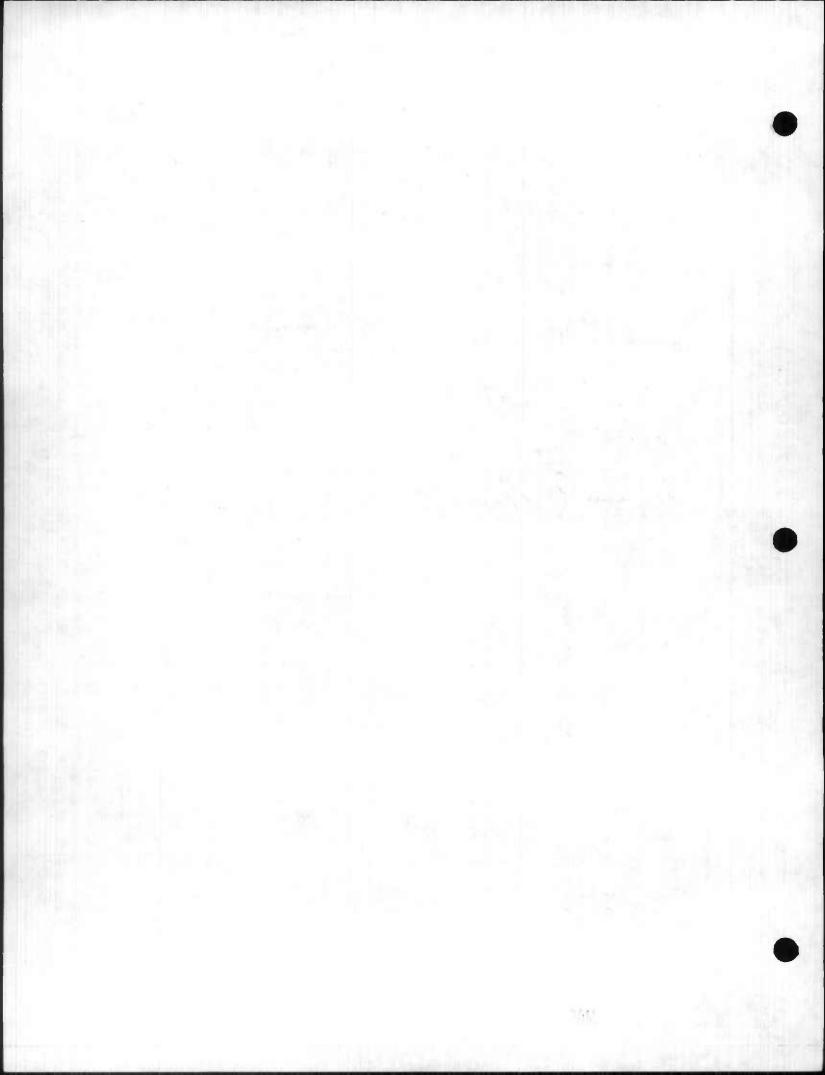
32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

EASTON, MD

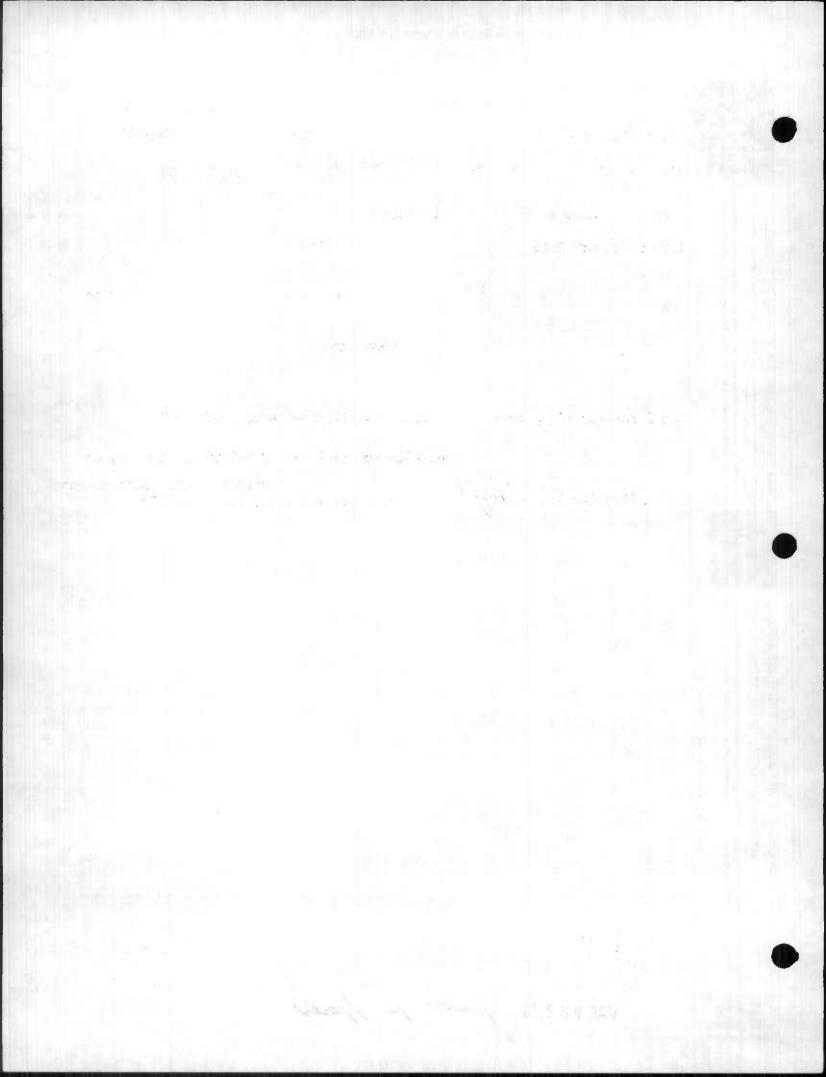
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Physician /Medical	Marie A	nna Price				March	3 20	Yeer 000	6:05pm
Examiner	4a Fecility Name (If not institution, giva 1503 Deer Park Ro	street and number) ad			4b. City, Town, or Lo Finksburg		4c. County Carro		
Funeral Director	5. Social Security Number 6. Sec 212-24-8561	7. Aga (In yrs. ia:	st birthday) If Unda Months	r 1 Yaar Days	If Undar 24 Hrs. Hours Min.	8. Dete of Birt (Month, Day Aug 11	h y, Year) 1928	9. Birthplac Country Md	ce (State or Foreign
show at a	Usual Residence of Decedant 10e. Stele 10b. County		Town or Location					10d	. Inside City Limits
the Meryla 28a-f shor neutrad at	Md Carroll 10e Street and Number		ksburg	n Coda			10g. Citizen of V	Vhat Country	1 ☐ Yas 2 🛣 No
23a or	1503 Deer Park Road			Coda 21 (USA		
# # # D	11. Marital Status 1 Never Merried 2 Married 3 Vidowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes:	. 13. Was Dece If Yas, spe		dispanto Origin? (Sp an, Mexican, Puarto Specify:	ecify Yes or No- Rican, atc.)	Bled	e - American k, White, etc. white	
To Be Completed by Fu	15. Decedent's Edu (Specify only highest gradi Elamentery/Secondary (0-12)	cation e completed) College (1-4or 5+)	16e. Decedent's Usu (Give kind of w life. DO NOT u homema	el Occup ork done ise ratire aker	pation during most of work d)	ing	16b. Kind of Bu	estic	atry
2 should be filled with and Mental Hygiene. Is marked other than reumatic event, the I	17. Father's Neme (First, Middla, Last) George J.	Prager			18. Mothar's Nem	e (First, Middle, trude D)e)	
ges 1 and 2 should be flied with to of Heelih and Mental Hygiene. If it flam 27 is marked other than or other traumatic event, the second	19e. Informant's Neme/Reletionship (Ty Carol Foreman (daug		19b. Mailing Addras					Stata, Zip C	ode)
or other	20e. Method of Disposition 1 🛱 Burial 2 🗆 Cramation 3 🗆 R 4 🗆 Donetion 5 🗆 Other (Specify)		ntion - City or Town, State ville, Md						
permit. Pa Depertmen Important: any Injury pnca.	21. Signeture of Funaral Service Licensu		22. Nama a	nd Addra	ses of Facility	ight Fur	neral Ho	me & (
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To the Hospital or Attanding I within 24 hours efter death of the Funeral Director. After completaly filled in by the funeral Medical Certification	3 Sulcide 6 Could not be 4 Homicide determined	28a. Place of Injury - At hom building, atc. (Specify)	ne, farm, straat, fecto	ry, office		28f. Location (: City or Tox	Straet end Numb wn, Stata)	per or Rural i	Route Number,
Ne Hospital n 24 hours ne Funeral pletaly filled edical Ce		elctan: To the best of my knowledge: On the basis of exeminetic and menner steled.							
To the comple	29b. Signeture and title of certifier		29	c. Licens	t 1869		29d. Dete algne	d (Month, D	ay, Year)
	30. Neme and eddress of person who co	mpleted cause of deeth (Itam 2	, /	T		R	Lingich	Mn	210
State	31. Dete filed (Month, Day, Year)	32. Registrar's Signatu	Greene	In	ee road	139	imone	(11)	71708

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State of Maryland / Department of Health and Mental Hygiene 0 0 9 7 5 9

Certificate of Death

			Certifica	ate of D	realli	F	leg. No.	
_	I. Decedent's Name (First, Middle, Las	st)			E	2. Date of Dea Month	th Dey	3. Tima of Deeth
sician edical _	Lieselotte	M. Parker					5, 200	
miner	a Facility Name (If not institution, give	e street and number)		4b	. City, Town, o	Location of Death	4c. County	of Death
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rai	. Social Security Number 6. S	ex 7. Age (In yrs. I	Month		If Under 24 Hi Hours Mi		, Year)	Birthplace (State or Foreign Country)
	220-74-5211 Jsual Residence of Deceden1	58	Yrs.			July18	,1941	Austria
-	10a. State 10b. County	10c. City	, Town or Location					10d. Inside City Limits
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Funeral Director						The state of		That Gooding !
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된	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	If Yes, s	pecify Cuban	, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Bled	k, White, etc.
by	3 Midowed 4 Divorced	If Yes, Give Year or Dates:	1□ Yes	2 No	Specify:		Specify	White
8	15. Decedent's Ed	ucation	16a. Decedent's U	suaf Occupat	tion			usiness/Industry
Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give kind of life. DO NO	work done du use retired)	uring most of w	orking		
E	12	College (1-401 54)	Homen	naker			Own	Home
1 80	7. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Sumem	e)
	Maxmillian Fim	berger			Una	vailabl	e	
	19a. Informant's Name/Relationship (7		19b. Mailing Addr	ess (Street ar		Rural Route Numbe		State, Zip Code)
	Cornelia Poudr	ier/Daughter	1621 Mi	ssion	n St.	Owings.	Md. 2	0736
	Oa. Method of Disposition	20b. Pl	ace of Disposition (/	Name of		Date		City or Town, Stata
	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removel from State Md.	Veterar Ltenham	ns Cer	ń.	06 00	Oh a l h a	mbom Md
9 2	21. Signature of Funeral Service Licen	see		and Address	- 4 F 18/4	eall Fu		nham, Md.
2	Shannon W. Bo	Bealf	6512	NT 147				ноте е, Md. 20715
	23a. Part1. Enter the disease, or comp							Approximeta
n l	shock, or heart failure. List only	one cause on each line.						Intervel Between Onset end Death
if the U	mmediate Cause (Final	METAST	ATIC	0	DLON	CAN	INDR	6 MONERS
er	disease or condition resulting in death)		as a consequence of			CATI	COL	, WINDER
9		Due to (or	as a consequence (,,.				
Examiner	Sequentially list conditions	b. Due to (or	as a consequence of	of):				
	Sequentially list conditions, fany, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events		2000					
edical	Cause (Disease or Injury hat initiated events resulting in death) Last	C. Due to (or	as a consequence of	n):				
N N	esoning in death) Last							
		d						
P	art II. Other significant conditions co	ontributing to death but not resu	Iting in the underlyin	g cause giver	n in Part I.	23b. Did 1	obacco uae cor	ntribute to the cause of death?
Physician/						101	100 2 No	3 Probably 4 Unknown
by -						-		
2						24a. Was a	an autopsy med?	24b. Wera autopsy findings available prior to
Completed								completion of cause of death?
FI						1 D Y	es 2000	1 ☐ Yes 2 ☐ No
ō					26. Place of D	eath (Check only or	ne)	I.
	5. Was case referred to medicat	Hospital:	ER/Outpatient 3	DOA Other	4 Nursing	Home 5 ☐ Resid	ence 6 toth	er (Specify) DAUGHTER.
e 2	avaminar?	1 Inpatient 2 E	001 T 1	28c. Injury	at ?	28d. Describe h	ow injury occurr	red
98 oF	axaminer? 1 Yes 2D No 7. Manner of Death	1 LI Inpatient 2 LI E	28b. Time of Injury					
90 P	axaminer? 1	28a. Date of Injury (Month, Day Year)	Injury M		es 2 No			
98 o 2	axaminer? 1 Yes 2 No 7. Manner of Death 1 Natural S Pending	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor	Injury M me, farm, street, fact	1 🗆 Y	es 2 No	28f. Location (S City or Tow	treet and Numb n, Stete)	er or Rural Route Number,
9 o 2	axaminer? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Injury M me, farm, street, fact	1 🗆 Y	es 2□No	28f. Location (S City or Tow	itreet and Numb n, Stete)	er or Rural Route Number,
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ledical Certification: To Be	axaminer? 1 Yes 2 No 7. Mapner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 No 1 Certifying Phyone	28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At hot building, etc. (Specify, reiclan: To the best of my know there: On the basis of examinati	Injury M me, farm, street, fact vledge, death occurr on and/or investigati	1 Year	o, date end pla nion, death oc number	City or Tow	n, Stete) cause(s) and ma date end place, (anner as stated. and due to the cause(s) d (Month, Day, Year)
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DHMH 16 Rev 6/95

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S. Social Socials New Number 1.00	DRINGE CEORGE					
State Stat	NCE GEORGES					
Second S	Birthplace (State or Fore Country)	ign				
10e. Stale 10e. County Prince George's 10e. City, Town or Location Bowie 10e. Stale Bowie 10e. Sta	73 Wash., D.C.					
Elementary/Secondary (0-12) College (1-4or 5+) Teacher	that Inside City Limit					
Elementary/Secondary (0-12) College (1-4or 5+) Teacher						
Elementary/Secondary (0-12) College (1-4or 5+) Teacher	of What Country?					
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To be to the first mame (First, Middle, Last) To be to to to the first mame (First, Middle, Last)	PRINCE GEORGES 9. Birthplace (State or Foreign Country) Wash., D.C. tod. Inside City Limit to Yes 2 DN Citizen of What Country? United States 14. Race - American Indien, Bleck, Whita, etc. Specify: Black b. Kind of Business/Industry P.G. Government iden Sumame) Vilson City or Town, State, Zip Code) C. Location - City or Town, Stete Landover, MD Deral Home 1., D.C. 20019 Approximate Interval Between Onset and Deeth					
Edward T. Phillips Securities Physician Physici		_				
20a. Method of Disposition 1						
20a. Method of Disposition 1	on wn, State, Zip Code) 20716					
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Physician /Medical Examiner Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury that initialed events resulting in death) Last Due to (or es a consequence of):	Stewart Funeral Home					
Physician /Medical Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): Due to (or es a consequence of):						
Immediate Cause (in Inal disease or condition resulting in death) Due to (or es e consequence of): Due to (or as a consequence of):	Interval Between Onset and Deeth					
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If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): 1						
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24a. Wes an autops performed?	of deaths					
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1 Yes 2 S						
27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Neutral 5 Pending investigation 1 Neutral 5 Pending investigation	Other (Specify) COUNT					

DIVISIO
To the Hospital or Attendi
within 24 hours after death
To the Funeral Director: A
completely filled in by the f Medical Certifica

3 Suicide
4 Homicide

6 ☐ Could not be determined

28e. Place of Injury - At home, lerm, street, lectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

t Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete signed (Month, Dey, Year)

O.C.M.E

MARCH 07,2000

30. Name and address

d caused death (Nem 23a) (Type, Print)

Nes tane 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date liled (Month, Day, Year)
MAR 0 9 2000

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TEBrucon 23 2000 carion of Death 4c. County of Death E LIBERT GO TAIN. 1547 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBURY
If Under 24 Hrs. | 8, Da PENINSULA REGIONAL MEDICAL CENTER WICOMICO 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 F 217-09-2092 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 W No Director WICOMICO MARDELA SPRINGS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 25890 21837 Norma 23a QUINTON USA Kd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married allimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) DUPPINT DEPORTMENT 64 permit. Pages 1 and 2 should be flix
Department of Health and Mental Hy
Important: if Item 27 is marked other
eny Injury or other treumette 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BYARD QUINTON HRDELLA (DUINTON) 10 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25890 QUINTON Rd. MARDELA Solius, Mp 2/837
e of Disposition (Name of Dete 20c. Location - City or Town, State (NIECE) MILE 20b. Place of Disposition (Name of cometery, cremetery or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremetion 3 □ Removal from State SHARPTOWN, MD 2/26/00 ZION CHURCH CEMETARY 4 ☐ Donation 5 ☐ Other (Specify) ervice Licensee 22. Name and Address of Facility BENNIE SMITH F/H 917-W. ESABELLEST. SALISBURY unce MD. 21861 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final AND JAJ W Que to (or as a consequence of): disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): P.O. Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part It. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cv Records, 24b. Were autopsy findings available prior to completion of cause of death? should s Completed 24a. Was an autopsy 1 Yes 2 KNo 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours efter death. ne Funeral Director: After ti After 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and matter. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) within 2 To the 9 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and who of garill 1557-P IN 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) Sallysbury, Ind 2,804 VAI 5 OC 00 on R 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar FFB 2 5 2000

DHMH 16 Rev 6/95

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Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death Month OUIGLEY JOANNE 10,2000 March 20:46 MARIE 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Calvert Memorial Hospital
cial Security Number 6. Sex 7. Age (In yrs. last birthday) Pr. Frederick Calvert If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 M 2 XF Deys Hours Min. Yrs. 161-48-7448 42 Aug. 14, 1957 PA Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD Calvert Lusby 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? USA

14. Raca - American Indian,
Bleck, White, etc. 385 Canyon Court 20657 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yas, Give Year or Detes: 1 Never Married 2 Merried 1 Yes No Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Harry Baynes Anna Bergen 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Intorment's Name/Reletionship (Type, Print) 385 Canyon Ct., Lusby, Maryland 20657
Lice of Disposition (Name of Dete 20c. Location - City or Town, Michael Quigley/spouse 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriet 2 Toremetion 3 Removal from Stete 4 Donetion 5 Other (Specify) 3/14/00 Alex., VA Metropolitan Crem. 22. Name end Address of Fecility
Raymond-Wood Funeral Home 21. Signeture of Funeral Service Ligensee P.O. Box 430, Dunkirk, MD 20754 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) cardiac arrhythmia Due to (or es e consequence of) Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Last Due to (or es a consequenca of) Due to (or es e consequença of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown melanoma 24b. Were autopsy findings 24e. Was an autopsy performed? available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 NER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28c. tnjury at Work? 28d. Describe how injury occurred 1 Se Netural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title

Box 68760 P.O. Records. Division of Vital Hospital or Attending Pt
 24 hours after death.
 Funeral Director: After the letely filled in by the funeral To the Hospital within 24 hours a To the Funeral C

Physician

√Medical

Examiner

Funeral

Director

r than "natural", or itsms 23a or 28a-f show the Medical Examiner must be notified at

al Hygiene.

parmit. Pages 1 and 2 should be fit Department of Health and Mertal H Important: if Item 27 is marked oth any Injury or other treumstic even Bross.

Physician

Examiner

the attending physician and thed for use as the burial-trans

signed by

this certificate

as the

Examiner

Physician/Medical

by

Completed

Be

10

edical Certification:

State

Registrar

Baltimore, Maryland 21215-0020

Directo

Funeral

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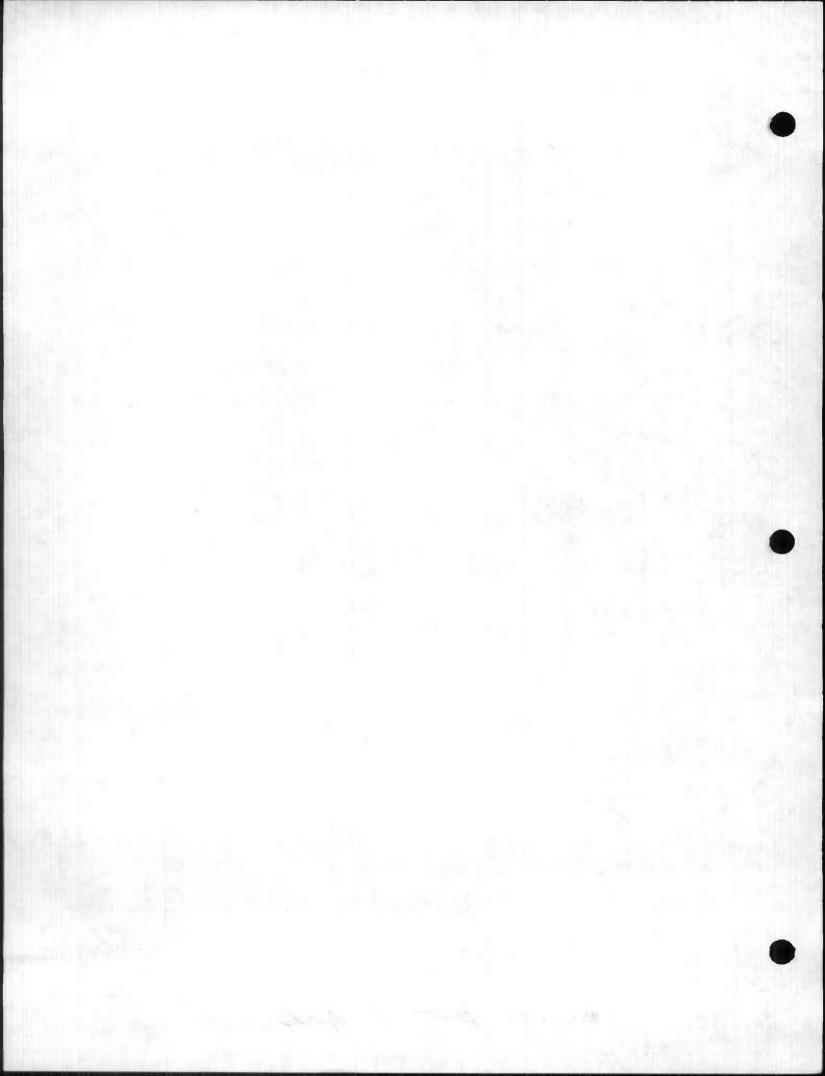
20

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Robert Schlager, M.D.

Prince Frederick, MD 20678

3-11-2000

32. Registrar's Signature MAR 1 3 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9763

						Ce	rtificate	e of	Death			Reg. No.		
Physic	ion	1. Decedent's Nem									2. Dete of De _Month_	Dov	Year	3. Time of Death
/Med			Mary			taino					March	3, 2	2000	8:30 AM
Exami	ner	4e. Fecility Neme (Heritage	(If not institution, gi e Harbour	ve street and n	umber)				4b. City, Tow Annap	17.	ocation of Deat		ty of Deeth Arund	el
Funeral Director	_	5. Sociel Security N 216–16–44		Sex 1□M 2X1F	7. Age (8	In yrs. lest birthday, Yrs.	If Under Months	1 Year Deys		4 Hrs. Min.	8. Dete of Bir (Month, De Jan. 3	th Year) I, 1913	9. Birth	olece (Stete or Foreign de Island
p .		Usuel Residence o	10b. County		1	On City Taylor and								
death with the Maryland ms 23a or 28a-f show Linust be notified at	ctor	Maryland	Anne Art	ındel		oc. City, Town or Li Annapo								1 ☐ Yes 2 💢 No
€ % E	Dire	10e. Streef and Nu	ımber				10f. Zip (Code				10g. Citizen of	What Cou	ntry?
234 west 2	Ta.	670 A	mericana Di	rive Apt.	# 27				21403			USA		
_ b 2 2	by Funeral Director	11. Meritel Stetus 1 Never Marr 3 Widowed	ried 27 Merried 4 Divorced	12. Wes Dec Armed F 1 Tyes If Yes, G Yeer or I	orces? 2V No live		Wes Decede If Yes, speci 1 ☐ Yes 2			in? (Spi Puerto	ecify Yes or No Rican, etc.)	Speci	ice - Americ eck, White, ify: Whi	etc.
72 hours	ted	/Sne	15. Decedent's E	ducation	n	16a. Dece	dent's Usuel	l Occup	petion	of work	ina	16b. Kind of I	Business/In	dustry
21215-0020 d within 72 hours af piene. If then "netural", or the Wedgell Earth	Be Completed	Elementery/Seco			(1-4or 5+)		nemaker		during most ()d)	or work	iiig	Own Ho	ome	
Nore, Maryland 212: gas 1 and 2 should be filed within it of Health and Mental Hygiene. If Item 27 is marked other than or other traumatic event, the M	To Be C	17. Father's Neme Richa	(First, Middle, Las	t)							e (First, Middle ne Traver	, Meiden Suma S	ime)	
ind 2 sho alth and N 27 le ma		19a. Informent's N Marian	lame/Relationship o Ristaino/				_					er, City or Town apolis, N		
Sarimore, Jemit. Pagas 1 ar Jepartment of Hea Moortant: If Nem: In Injury or other Mose.		20a. Method of Dis				20b. Plece of Dispo cemetery, cre	sition (Nam	e of		-	Dete	20c. Location		
Page nent on			☐ Cremetion 3 [5 ☐ Other (Special		n Stete	St. Mary's			,	C	3-07-00	Annapoli	is, Mar	yland
Dailimore, Mi permit. Pagas 1 and 2 Department of Health a Important: if hem 27 le any injury or other tra once.		21. Signature of Fi	uneral Service Lice	Poem	Λ	() 2	2. Name end	d Addre	ess of Fecility	Jo	hn M. Ta	ylor Fune	eral Ho	me, Inc.
D 805 8 8		DE.	Suan	1/00	للعر	X	147 Duk	ce o	f Glouce	ster	Street	Annapoli	is, Md.	21401
Certificate be axecuted Certificate be axecuted Certificate and Certificate and Certificate as the burial-transit Certificate as the burial-transit Certificate Ce	Jicai Examiner	Immediate Cause disease or condition resulting in deeth) Sequentially list confiantly, leading to incause. Enter Unde Cause (Disease or that initieted events resulting in death)	onditions, nmediate erlying i injury	b	De	e to (or as a consection of the consection of th	quence of):		dis			dent		Months Months
	an/Medical		·	d	(0)	(000/7	ase	7	dis	er	•			415
. 0 00	Physician	Part II. Other signif	ficant conditions	contributing to	death but n	ot resulting in the u	nderlying ca	iuse gi	ven in Pert I.		23b. Did	tobacco usa c	ontribute to	o the cause of death?
- E & S	Ph										10	Yes 2□ No	3 Pro	bably 4 Unknown
requires been sign should be	Completed by											en autopsy ormed?	av	ere autopsy findings alleble prior to impletion of cause death?
	Eo										10	Yes 20 No		□Yes 2□No
Physician: The this certificate ral director, pag	BeC	25. Wes case refer	rred to medical	I					26. Piace o	of Deetl	h (Check only		1	2.00 22.00
- 5 m	ToE	examiner?	No	Hospitel: 1 🗆	Inpatient	2 ER/Outpatie	nt 3 DO/	A Oti	her:	-		dence 6 🗆 O	ther (Specia	(y)
Attending Physic death.		27. Menner of Deet 1 □ Natural 2 □ Accident	th 5 Pending investigetic		of Injury oth, Dey Yo	28b. Time o Injury	f 28	Bc. Inju Wo	ryet rk?]Yes 2 □ N		28d. Describe	how injury occu	urred	
5 6 5 5	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not to	286. Piec	ea of Injury ding, etc. (S	- At home, ferm, str Specify)	eet, factory,	office			28f. Location (City or To		ber or Run	al Route Number,
Lothe Hospital within 24 hours To the Funeral I	edical (29a. Certifier (Check only one)	1 Certifying P	miner: On the A	best of masis of examples steted	ny knowledge, deet aminetion and/or in 1.	occurred a vestigetion,	t the ti	me, date and opinion, deeth	piace,	and due to the ed et the time,	cause(s) and n date and ptece	nanner as s , and due to	teted. o the cause(s)
To th To th Comp	Me	29b. Signeture end	V. Jou	M	1		29c.	Licen	se number 419	28	3	29d. Dete sign	7-0	00
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12th 17. Father's Name (First, Middle, Last) Hart Rainsford 19a. Informant's Name/Relationship (Type, Print) Woodrow L. Rainsford 20a. Mathod of Disposition 1 Buriel 2 Cremation 3 Ramove 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensea 23a. Part I. Enter the disease, or complications brock, or heart failure. List only one caus lician disease or condition rasulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Part II. Other significant conditions contribution Part II. Other significant conditions contribution							pat mi	l Anh naci		A . Ab				
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To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fo

29a. Certifiar (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, deta and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licansa number 830692 29d. Dete signed (Month, Day, Year)

28e. Place of Injury - At homa, tarm, streat, factory, offica building, atc. (Specify)

29b. Signatura and title of certifier

6 Could not be datermined

MARCH 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

20850

State Registrar

Medical Certifica

4 Homicida

15225 - SHAPY GROVE ROAD ROCKVILLE BERREEI GABRIEL A 31. Dete filed (Month, Day, Year)
MAR 1 0 2000 32. Registrar's Signatura

NA - 1 0 4 15/11

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** William H. Robinson, Sr. March 1, 2000 2:55 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner VA Maryland Health Care System Perry Point Cecil If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 12 M 2 F Yrs. 215-16-3740 79 Director Oct. 24, 1920 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits rs 23s or 28a-f shor must be notified at 1 ☐ Yes 2 No Directo Maryland Mardela Springs Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11578 Norris Twilley Road 21837 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 2 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2000 Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th mechanic Dupont Company 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Daniel Richard Robinson Rolena Ollie Jolley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Gloria Wigfall/daughter 1520 Esquire Drive - Salisbury, Maryland 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Robinson Family Cemetery 3/09/00 Vienna, Maryland 21. Signeture of Funeral Service License 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD JOLLEY MEMCRIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each one. with. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Hyperosmolar Coma 2 Days Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Multi-infarct dementia py 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to Completed completion of causa of death? page 2 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ EFVOutpatient 3 ☐ DOA 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. tnjury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Directory letely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical completely (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier Sodh D42014 March 1, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURINDERPAL SODHI, M.D., VA Maryland Health Care System, Perry Point, MD 31. Date filed (Month, Day, Year)

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after death. Director: Aft

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'natural', or itsms 23s or

21215-0020

Maryland

altimore, WILLIAM

Pages 1 and 2 should be

the death certificate be executed

Box 68760.

P.O.

Records. The law requires

Division of Vital or Attending Physician: reportant: If Item 27 is marked

Health

PHYSICIAN

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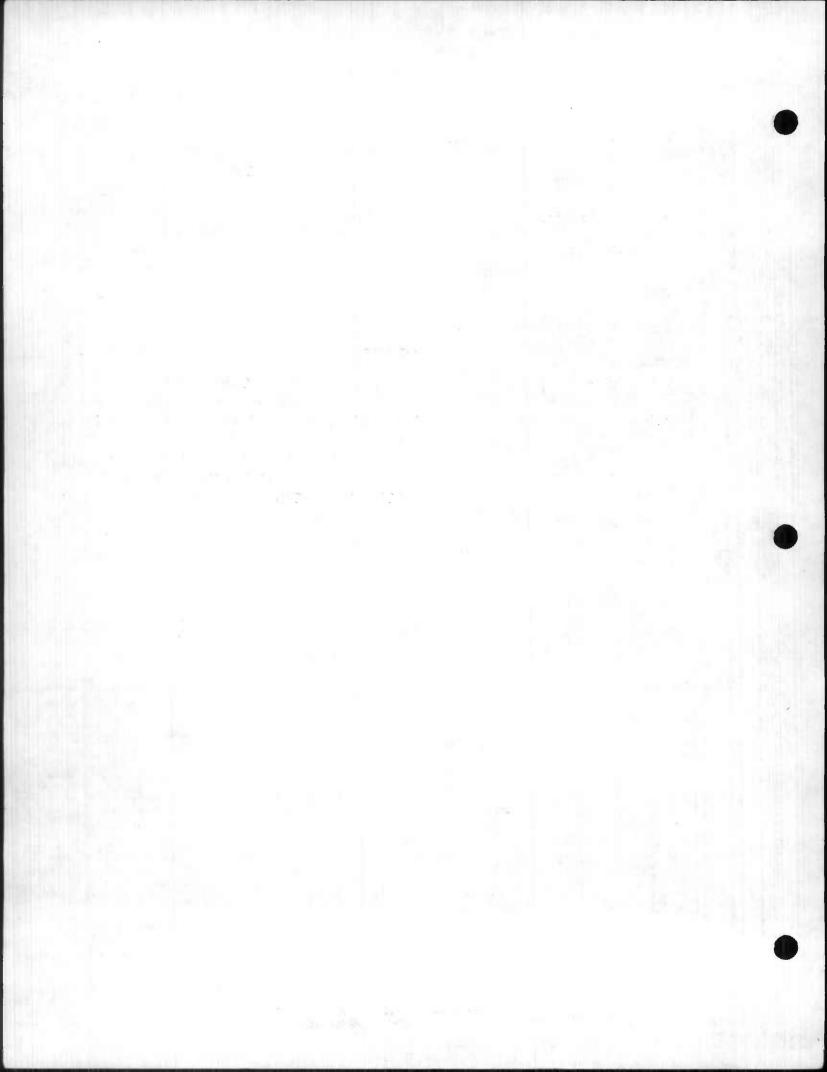
ROBINSON

State Registrar

MAR 0 9 2000



Sparker



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 2000 Month **Physician** SABRINA LYNN RICKARDS March 02, 1:25 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Peninsula Regional Medical Center Wicamico If Under 24 Hrs. H Under 1 Year 8. Date of Birth (Month, Day, Year) 7/16/1979 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1□M 28 F LEWES. 222-60-6050 20 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits DELAWARE SUSSEX FRANKFORD 1 ☐ Yes 2 No Director 280-7 10e. Street and Number 101. Zip Code 10g. Citizen of What Country? 23a or R.D. 2 BOX 195 19945 USA Funeral Berra Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specific py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) 12 CHILD CARE CHILD CARE PROVIDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental DAVID O. RICKARDS RITA HOLSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 Is other tra DAVID O. RICKARDS / FATHER R.D. 2 BOX 195, FRANKFORD, DE 19945 20a. Method of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) = 5 MILLSBORO CEMETERY 3/6/00 MILLSBORO, DE 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility WATSON FUNERAL HOME, MILLSBORO, DE atson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 980 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes ANO 3 3 Probably 4 Unknown à Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy

been signed to should be det The law requires pege 2 certificate or Attanding Physician: this 24 hours after death. Funeral Director: A

Division of Vitai

Completed Be Certification: To

25. Was casa referred to medical

Yos 2□ No 27. Manner of Death 1 Natural 5 Pending 2 Suicident 3 Suicide

4 Homicide

29a. Certifier

one)

Investigation 6 Could not be determined

26 00

28b. Time of 000/ 21 Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes a No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d/) Describe how injury occurred

5 Septiles 10 accident Location (Street and Number or Rural Roc City of Town, State)

completion of cause of death?

2 □ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 No

29c. License number orless

O.C.M.E.

29d. Date signed (Month, Day, Year) March 03, 2000

ass of person who completed cause of death (Item 23a) (Type, Print) 1 mg

Hospital:

111 Penn Street, Baltimore, Maryland 21201

26. Place of Death (Check only one)

State Registrar

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filled in by

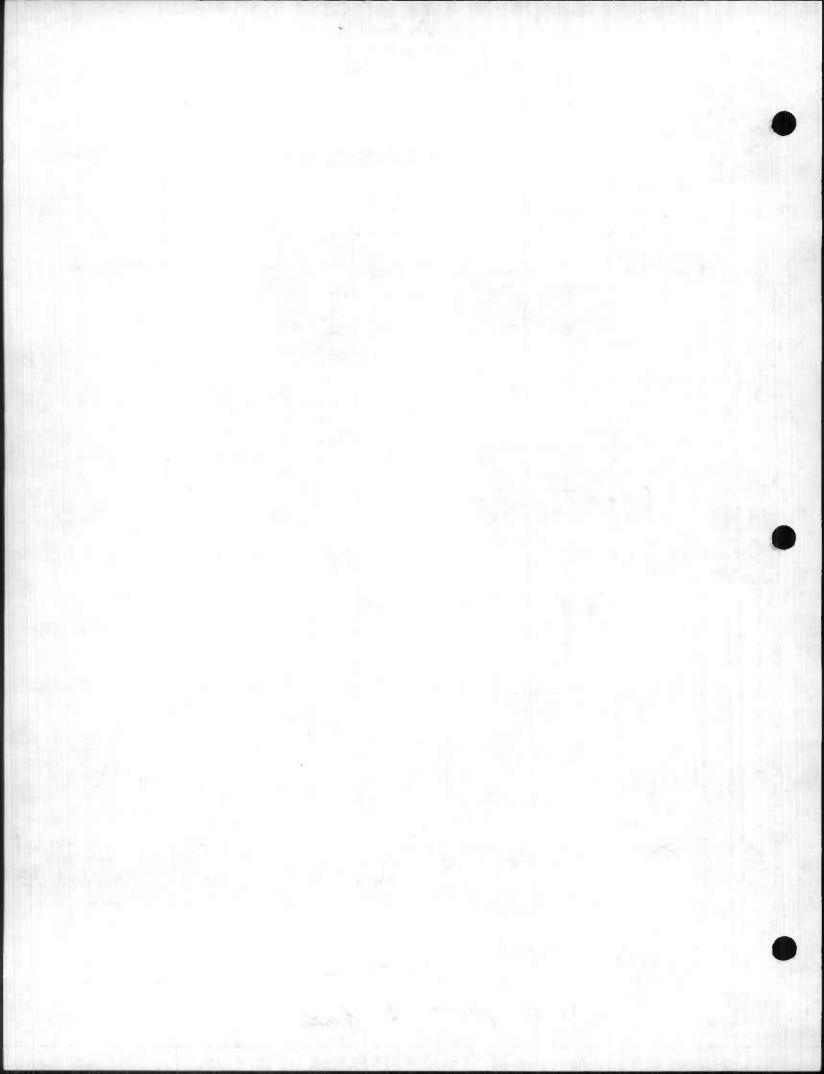
Medical

Hospital

within 2 4

> 31. Date filed (Month, Day, Year) MAR 0 6 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09767. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Data of Death Month Vaar **Physician** MARY RESSEGUE 2038 March 2000 /Medical 4c. County of Death 4e Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 DOF 189-09-3261 87 **Director** June 19,1912 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Wicomico Salisbury 28a-f Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21801 604 Eton Circle USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. 11 Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: þ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chris Craft Industries Executive Secretary 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surnama) Be If Nem 27 is marked o Pages 1 and 2 should Thomas Peter Gordon Rose Ann Rees 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Dennis Gordon/Nephew 2319 Gerken Ave., Vienna, VA 22181 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: Il any injury o 2008. Springhill Memory Gardens 3/6/00 Hebron, MD 22. Name end Address of Fecility
Holloway Funeral Home Professional Association 21. Signature Funeral Service Licensee M01051 501 Snow Hill Rd., Salisbury, MD 21804 Mompons 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Physician Immediata Causa (Final diseasa or condition rasulting in death) /Medical CEREBRULASCULAN ACCEPENT 24 Han Examiner Due to (or as a consequence of): Examiner the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be execu Box 68760. Physician/Medical Due to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown RENA FAILUNG Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed PIBRILLATION 1 Yas 2 No 1 Yas 2 No certificate of Vital or Attanding Physician: funeral director, 25. Was casa referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending 1 Yas 2 No death. investigation 2 Accident 24 hours after deal Funeral Director: 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the \$

Registrar

29b. Signeture end titla of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 2000

m.O.

32. Registers Signature

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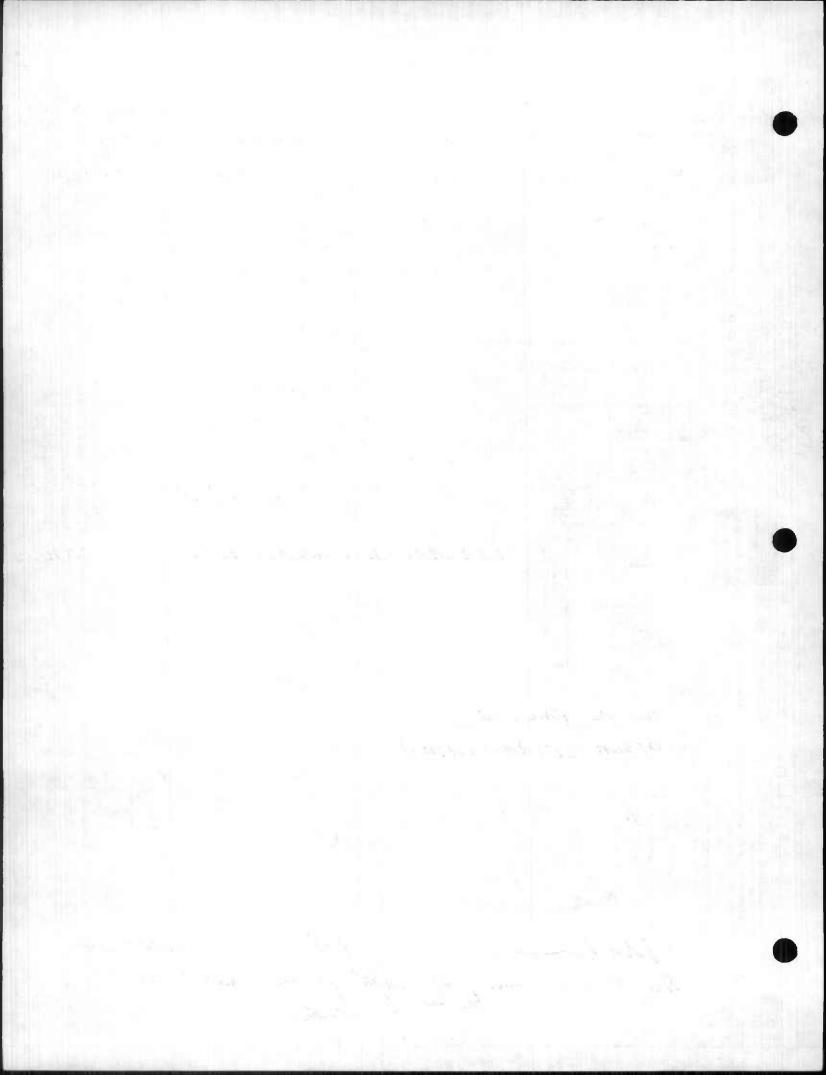
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400 Egsten

29c. Licansa number

29d. Deta signed (Month, Day, Year) MARCH 3, 2000

59/15bury,



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dele of Deeth 3. Time of Death Dey 00 MARCH 01 6:07P.M. Anna R. Reed 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth CAROLINE NURSINGHOME, INC. DENTON, MARYLAND CAROLINE 7. Age (In yrs. lest birthday) If Under 1 Year if Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 2/4-20-072 8. Dete of Birth
Month, Day, Year) 9. Birthpieca (Stete or Foreign Country) 1□M 20 F Yrs. Usuel Residence of Decedent 10e, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits (hincoteague Accomack Virginia 1X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6282 (Leveland Street U. S. A. 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Deles: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Elizabeth Sharpley John Taylor 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Reute Number, City or Town, State, Zip Code). 6282 (Leveland Street, (runco teague, Virginia 23336 Lloyd N. Reed Husband 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 3-5-00 John Taylor Cemetery enperanceville, 21. Signeture of Funerei Service Licensee Salver Puneration Home Chinco teague, Virginia 23336 23a. Pert1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onsel and Death immediate Cause (Final disease or condition resulting in deeth) NEUMONIA Due to (or es a consequença of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequença ol): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown artery disease 24a. Wes an eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 1 Yes 20 No 1 ☐ Yes 2 ☐ NO 28. Place of Death (Check only one) Hospitel: t ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred

physician and s the burial-transit law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, 88 ettending p signed by the e s certificate has b Hospital or Attending Physician: funeral director, this death.

Physician /Medical

Examiner

Physician/Medical Examiner by Completed Be To

Physician

/Medical

Examiner

Director

Funeral

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2

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avent, the Medical France.

Certification: after deat Director: filled in by

State Registrar

edical

25. Wes case referred to medical examiner?

1 Yes 2 No 27. Menner of Deeth 5 Pending investigetion 1 Neturei 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. 29a. Certifier (Check only one)

29b. Signeture end title of certilier

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

James 31. Dele filed (Month, Dey, Year) MAR 0 6 2000

32. Registrar's Signeture Benero

24 hours

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 0634 PANSY 28 00 ELLEN RIALL Fevo /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Dete of Birth (Month, Day, Year) **Funeral** 1 M 2 X F Months Days Hours Min 214-10-7210 Yrs. Director May 26,1918 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits worle or hams 23s or 28s-f shov aminer must be notified at Wicomico Maryland Delmar 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 30408 Mallard Drive 21875 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, atc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: natural', or 1 ☐ Yes 2 No Specify Specify: À White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health end Mentel Hygiene. Important: If Item 27 la marked other than "any Injury or other traumatic avant, the Means Injury or other traumatic avant, the Means Elementary/Secondary (0-12) College (1-4or 5+) 11 Owner/operator H & J Drive In Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Lance Merrill Inslev Mary Ellen Horsman 2 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jeff I. Riall/Son 7703 Rockawalkin Rd., Hebron, MD 21830 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 ☐ Removaf from State 3/1/00 Wicomico Memorial Park Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Holloway Funeral Home Professional Association 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximata tntervel Between Onset and Death Physician Immedieta Causa (Final disease or condition resulting in death) ALCVO Examiner Due to (or as e consequence of): Examiner Cardomonth The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): 4days Box 68760, Fractured (2 Physician/Medical Due to (or es e consequence of): 4days Contrisions Multiple Pelviz signed by the e Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DM Completed by Records, 24b. Wera autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 No of Vital or Attending Physicien: 25. Was casa raferred to medical examiner?
1 ☑Yes 2 ☐ No Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Certification: To this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division After 5 Pending investigation 1 Netural 1 Yes 2 No To the Hospital or Attendition within 24 hours after death.
To the Funeral Director: A completely filled in by the f death. 2/23/00 WOON Slipped on ramp 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Salistany, mo Red Dail Sub Shop 1800 S. Swicky SIVO 21801 Medical 29a. Cartifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end mennar as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 2/28/00 (H5045) DME 30. Name and addrass of person who complined causa of death (Item 23a) (Type, Print) 5 Chris Snyden MD.

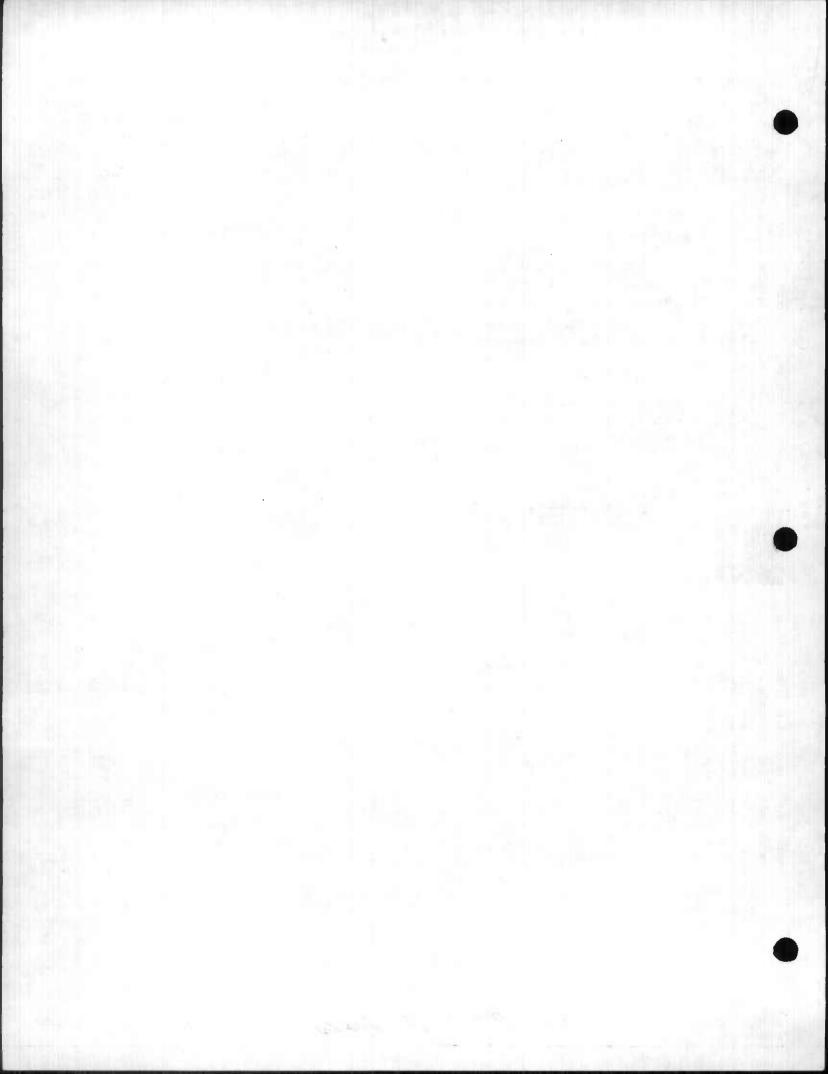
31. Dete filed (Month, Day, Year) 106 milford -81. Swite 201 Salisbury Md. 21801 32. Registrar's Signeture State Registrar

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State of Maryland / Department of Health and Mental Hygiene

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or 28a-f show be notified at Director	DELAWARE	SUSSEX		RE	новотн								Yas 2□No	
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r traum	19a. Informant'a Nam STEWART					WAINW				ROCKVI			th ERY Implice (State or Foreign (State) (State or Foreign (State)) HINGTON, D. 10d. Inside City Limits Yas 2 No ountry? Industry VERNMENT Zip Code) 0851 Town, State LAWARE Approximate interval Between Onset and Death Onset and Death Were eutopay finding a available prior to completion of cause of deeth robably 4 Unknown (State) 1 Yes 2 No output (State) 1 Yes 2 No output (State) 2 No output (State) 2 No output (State) 3 Stated. 4 Output (State) 4 Output (State) 5 Stated. 6 to the cause(s) 1 No output (State) 2 No output (State) 3 No output (State) 4 No output (State) 4 No output (State) 4 No output (State) 5 No output (State) 6 No output (State) 6 No output (State) 6 No output (State) 6 No output (State) 7 No output (State) 8 No output (State) 9 No output (State)	
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any l	21. Signature of Funeral Service Leonsee MO0866 22. Name end Address of Fecility PARSELL FUNERAL HOME & CREMATORIUM 1449 KINGS HIGHWAY, LEWES, DE 19958 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,													
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pletaly fille	29a. Certifier (Check only 2 one)	Certifying Pt	miner: On the b	asis of exemine	wledge, death tion end/or inv	occurred at vestigetion, in	the tin	ne, date ar pinion, dec	nd place, oth occur	and due to the red et the time	cause(s) end date end pled	menner as e, and due	stated. to the cause(s)	
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State Registrar	30. Name and addres A NUSH 31. Date fliad (Month,	DADO	32.F	ANT	USH DA	DGAR,		6. 13:	219	EXECUTI	VE PK.	TERRA(CE, GERMAN- NN, MD20874	

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Lila Respass 17 2000 1050 February /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death-4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 1 F 79 Director 240-24-3989 Jan 13, 1921 NC Usual Residence of Dece the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1805 Jersey Rd. 21801 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black by 3X Widowed 4 □ Divorced Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filled wil Department of Health and Mental Hygient Important: If Item 27 is marked other that enty fulury or other traumatic avent, that PARSE. Domestic Engineer n/a 8th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Jerry Newsome, Sr. Rosa Britt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Smiley/daughter 1805 Jersey Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slete 1 Burial 2 Cremetion 3 Removal from State 4 □ Donation 5 □ Other (Specify) Philippi Bapt Church 2/22/00 Cofield, NC 21. Signature of Fuperal Service Licen 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Parti-Emer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner ician and burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): HYPERTENSIO physician s the burie Physician/Medical Due to (or es a consequence of): 080 for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Box 68760. 0 م Records. Division of Vital

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Completed page 2 s certificate Be Certification: To this After Attending To the Hospital or Attanding within 24 hours etter death.

To the Funeral Director: Atta completely filled in by the fun.

1 Yea 2 No 1 ☐ Yea 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No investigation 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only

29c. License number

24872

State Registrar

edical

29b. Signeture and title of certifier

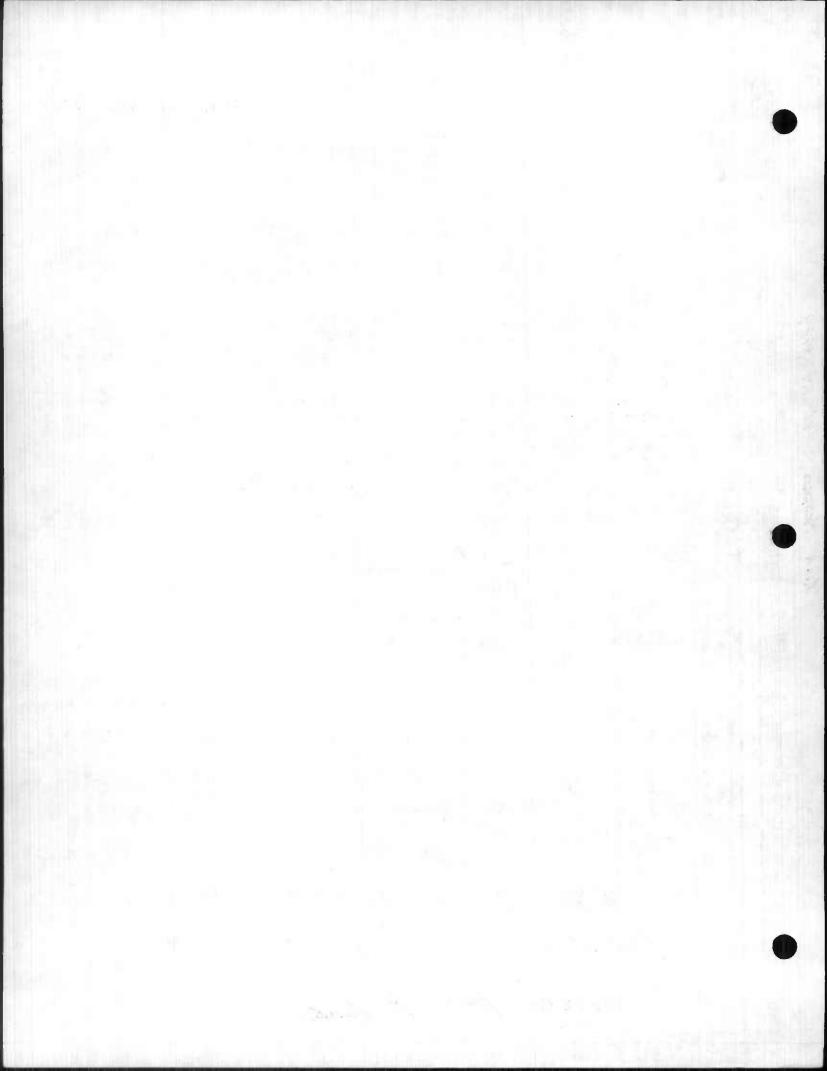
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30. Name and address of person who completed cause of death (ttern 23a) (Type, Print) De

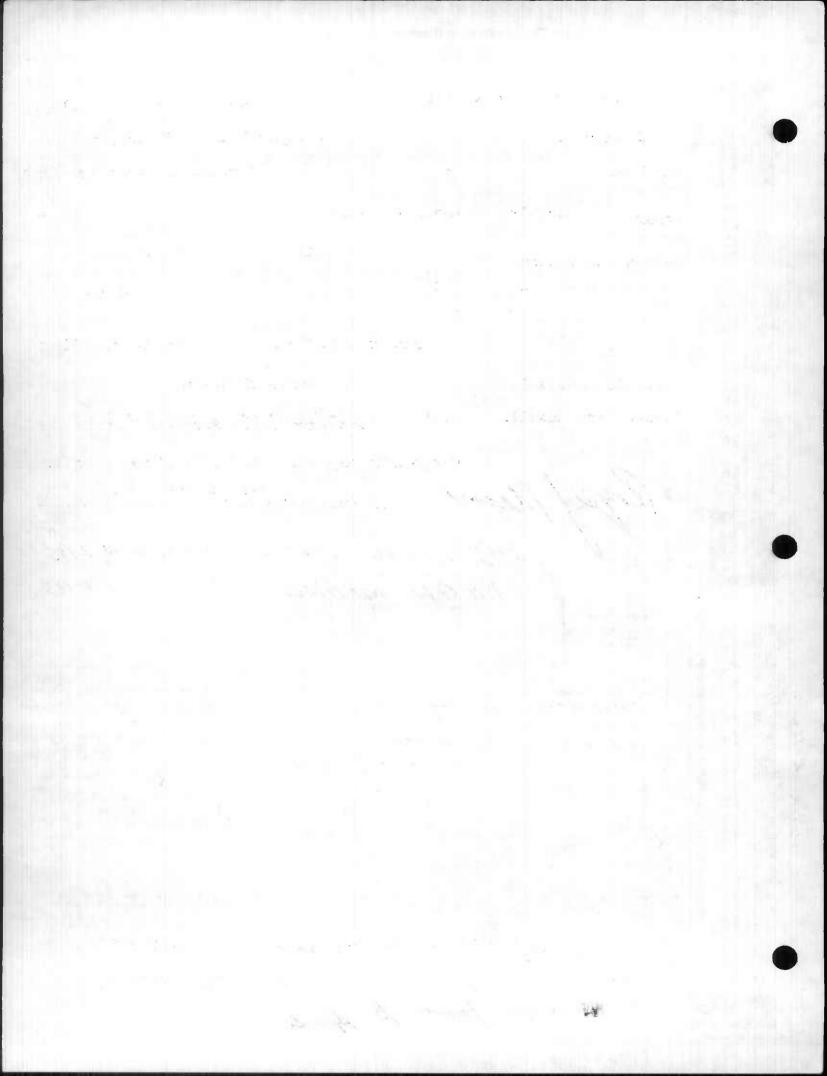
29d. Date signed (Month, Day, Year)

2/18/00



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					Cei	rtificate	of Death		Reg. No.		
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/Medical Examiner		(If not institution, gi		ber)				on, or Location of I		nty of Death Mary	s
Funeral Director	5. Social Security 0 4 9 – 1 8 –	-5467	Sex 10 M 20 F	7. Age (In yrs. 73	lest birthdey) Yrs.	If Under Months	Year if Under 2 Days Hours	Min. 8. Date of (Mont) Octo	ber 29,	9. Birthi 1926	place (State or Foreigntry) Connecticul
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Dacedent's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Daath **Physician** Month Vaar Harry Reph. Sr. 2000 3:00 p.m. March /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 602 Buttonwoods Rd. Elkton Cocil 8. Date of Birth (Month, Day, Y 5. Social Security Number If Undar 1 Yaar if Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) New Jersey **Funeral** Days Hours Months 10 M 20 F 216-20-3405 88 Yrs. **Director** Usual Rasidanca of Dacedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits must be notified at 1 X Yas 2 □ No Director Maruland Cecil Chesapeake City 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò 230 210 Bohemia Ave. 21915 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yas, Giva Yaar or Datas: 11. Maritel Status 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) or items 14. Race - American Indian, traumatic event, the Medical Examiner Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours efter 1 Naver Marriad 2 Married 21215-0020 1 ☐ Yas 2 No by 3 Nidowed 4 Divorced "naturel", White Completed 16a. Dacedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decadant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) Collage (1-4or 5+) Custodian 6 Public Schools other Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be h end Mental h Robert Reph Minnie Walton 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) or other tra Diane Martino/Daughter 602 Buttonwoods Rd. Elkton, MD 21921 Baltimore, 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Dete 1 Burial 2 Cramation 3 Removal from State Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) Gracelawn Memorial Park 3-13-00 Wilmington, Delaware 21. Signatura of Funaral Sarvice Licensee 22. Nama end Addrass of Facility R. T. Foard Funeral Home, P. A. 23a Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immadleta Causa (Final disease or condition rasulting in death) **Examiner** Examiner Sequantially list conditions, if eny, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that Initieted avants rasulting in death) Last and **buriel-tran** The lew requires that the death certificete be execu Division of Vital Records, P.O. Box 68760 ettending physician Physician/Medical Due to (or es a consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ete hes been signed by page 2 should be detect 1 Yes 2NO 3 Probably 4 Unknown þ Completed 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: certific Be (25. Was casa rafarred to medical 26. Pleca of Death (Check only ona) Other: 4 Nursing Home 5 PRasidance 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatlant 2 ☐ ER/Outpetiant 3 ☐ DOA After this funeral 27. Menner of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding deeth. 1 Yes 2 No invastigation 2 Accidant ofter deeth Director: filled in by the 3 Suicide 6 Could not be Place of Injury - At home, ferm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide o the Hospital within 24 hours e To the Funeral C 1 Crtifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and mennar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta and place, end due to the causa(s) end menner steted. 29a. Certifier Medical completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 ausa of deeth (Itam 23a) (Type, Priot) 32. Registrar's Sonatura State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3 Time of Death **Physician** Margaret L. A
4a Facility Name (If not institution, give street and number) March 2000 9:05 a.m. · /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Kemper 6/Sex Avenue estminster
If Under 24 Hrs. 8. Date of Bi 30 Carroll If Undar 1 Yaar 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (in yrs. lest birthday) 10 M 20 F Days Min. 92 Yrs. 219-20-4293 Usuai Residence of Decedent Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Moulcal Examinet must be notified at 12 Yes 2 No Director Westminster 10a. Street and Number 10a, Citizen of What Country? U.S.A 30 Avenue 21157 Funeral death Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amaricen Indien, Black, White, etc. 11. Marital Status 1 Yes 2 No ff Yes, Give Year or Dates: pernit. Peges 1 and 2 should be filed within 72 hours effer Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or ite 1 ☐ Never Married 2 ☐ Married 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Benjamin S. Floh Fowble -arric 19e. Informant's Name/Reletionship (Type, Print) 19th Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of camelery, cremetory or other place)

20b. Place of Disposition (Name of camelery, cremetory or other place)

20c. Location - City or Town, State Betty Bish-daughter
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State any injury or o 4 □ Donation 5 □ Other (Specify) 3.12.00 Westminster, MD. Kriders Cemetery 22. Name and Address of Facility

22. Name and Address of Facility

7. It's Funcial Home & Chape I, P.A.

23a. Pert1. Enter the Asease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting In death) accident Cerebrovascular Examiner Due to (or as a consequence of): Examiner physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementi's Division of Vital Records. by sining node dyspunction 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed After this certificate hes 1 Yes 20 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Wes case referred to medicat examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1. Neturel 5 Pending Invastigation 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral D 29a. Certifier 1 Acrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. within 2 29b. Signature and title of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 51705 3-10-2000 MAGANBHAI PANSURIYA, M.D. 30. Name and address of person who completed ceuse of death (item 23a) (Type, Print) Malcola Westminster

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Dey, Year)

MAR 1 0 2000

32. Registrer's Signature

Arran v 1000 1705 an Westminster Limit 35 Nemper Hyenac St. State year 29 7 1774-02-153 Palanimizati Nestminatar sunskin raymet. Di Silven nov s SHERRANTI 30 Congres Aronne med singles but will T Felly thing sugator AND THE CONTRACTOR OF THE CONT

Please Type or Print In Black indelible ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day MARCH 8,2000 15:00 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 4, 1920 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Say 7. Age (In yrs. lest birthday) Months 1 M 2 XF 212-54-6557 80 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Calvert Sunderland 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? USA 20689 5235 Hardesty Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home Domestic 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Contee Rice Josie Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lothian, MD 20711 5673 Old Ridge Path Doris Reed Gross/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State St. Edmond's UMC Cemetery 3/15/00 Chesapeake Beach, MD 4 ☐ Donalion 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funerel Service Licensee reinel 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onsel and Deeth Immediete Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 2-3 mm/t Sequentielly list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Rempheral vascular diseane 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

Physician /Medical Examiner

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√Medical

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Funeral

Director

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25. Was case referred to medical 1 Yes 2 No 27. Menner of Deeth Natural Accident

3 Suicide

29a. Certifier

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5 Pending investigation

6 Could not be determined

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end little of certifier almyonsar

MAR 1 3 2000

29c. License number Doo 27189 29d. Date signed (Month, Day, Year) 00

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

ZAHIR YOUSAF, MD 31. Date filed (Month, Day, Year)

32. Registrat's Signeture

HUNTINGTOWN;

State Registrar

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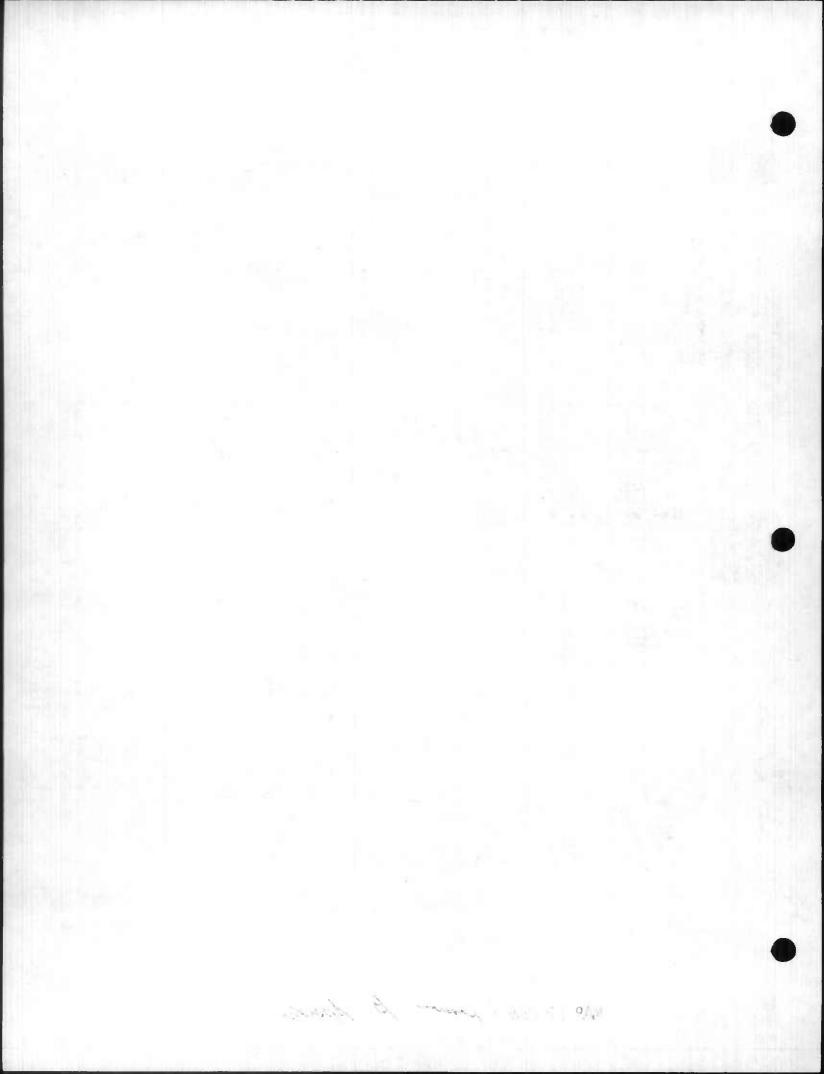
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State of Maryland / Department of Health and Mental Hygiene 0 0 9776

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Funeral Director	213	18 8564	6. Sex 1 □ M 2 □ XF	IM 2 THE 70 Months Days Hours Min.					8. Date of Bir (Month, De 1ay 10			lace (State or For try) yland	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ${\sf U}$ Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Des Yeer March 2000 11:05 a.m. PETER ROTA ANTONTO 4b, City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Clinton If Under 24 Hrs. Southern Maryland Hospital Prince George's If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) 5. Sociei Security Number 7. Age (In yrs. lest birthdey) 6 Sex Birthpiece (State or Foreign Country) Min 1 M 2 □ F Months Deys Hours Yrs. 577 76 7606 44 July 19, 1955 Washington D.C. Usuet Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City. Town or Location 1□Yes 2□No Prince George's Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7204 Goblet Court 20735 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No if Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bieck, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: Black. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) College (1-4or 5+) Eiamantary/Secondary (0-12) Engineer Technician Private 18. Mother's Neme (First, Middle, Maidan Sumama) 17. Fether's Neme (First, Middle, Last) Pearline Johnson Anthony Rota 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 7204 Goblet Court Clinton, MD 20735 Jacqueline Bush Rota/wife 20b. Ptece of Disposition (Neme of cematery, cremetory or other placa) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete Maryland Veterans Cem. 3-9-00 Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses MARSHALL'S FUNERAL HOME 4308 Suitland Road Suitland, Maryland 20746 a, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause diversity arrest. Approximete Intervel Between Onset end Deeth Immediate Ceusa (Finel diseasa or condition resulting in deeth) Sequantielly list conditions, if any, leading to immadiata causa. Entar Underlying Ceusa (Diseese or Injury that initieted events rasulting in deeth) Lest Due 18 Due to (or es e consequenca of): 23b. Did tobacco ues contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown rescon 24b. Were eutopsy findings available prior to completion of cause of daeth? 24e. Wes en eutopsy 1 Yes 2 No 1 TYes 2 TNo 25. Was casa referred to medical examinar? 26. Placa of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural tniury 5 Panding

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Department of Health and Mental Hyg.
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Records, P.O. Box 68760,

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the death certificate be executed requires that The law or Attending Physician: To the Funeral Di Hospital

Certification:

edical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature an

Registrar

1 Yes 2 No 28a. Placa of Injury - At home, farm, street, fectory, office building, etc. (Spacify)

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29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and dua to the ceuse(s) end menner as stated.

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28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Name end addrass of person who complated ceuse of daath (Itam 23e) (Type, Print)

Norman 4 10274 LANCE ARBOR WAY # 202

31. Dete filed (Month, Dey, Year) MAR 0 8 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month 4:10 PM MARCH 2, RITA RILEY 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOVENTIST HOSPITAL TAKOMA PARK WASHINGTON MONTGOMERY If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days 10 M 20 F Months Hours 579 48 7273 68 TUNE 2, 1931 WASHINGTON, DE Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits D.C. IN ASHINGTON 1 Yas 2 □ No 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 45A 20019 5732 S.E. 4THERH AUE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 Yas 2 No Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ASST FOR THEBLIND OCCUPATIONING REMAS 17 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) JACKSOH JENNIE Williams DAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOUTHERN AUE S.E., a-HERY 5732 KASHNGTON, D.C. 20019 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) FOREST Itills CENETCEY MADIGOD CLINTON, MARYHANS 22. Nama and Addrass of Facility SAM BUTLER & SONS INC FUNSERY 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximata Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Linknown age renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Examiner

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Baitimore, Maryland 21215-0020

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Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

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8a. Data of Injury (Month, Day Year)

28c. Injury at Work? 28b. Tima of Injury 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

2 LI Accident	
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4 Homicide	dete

28e. Plece of Injury - At homa, larm, street, lactory, office building, etc. (Specify)

28l. Location (Street and Number or Rural Route Number, City or Town, Stete)

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**Exertifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

Jo. O'graforo ano in	HE OF CERTIFIER
	0
X	Cal

29c. License number

29d. Data signed (Month, Day, Year) 3.3.00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMAN CULI-

ld not be

3503 Peny Street-

State Registrar 31. Data filed (Month, Day, Year) MAR 0 7 2000 32. Registrar's Signatura

To the Hospital or Attending Physikin 24 hours efter death.
To the Funeral Director: After the completely filled in by the funeral

dente

DOL TO HAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 9779

	AMEND#	10b 3/8/00 cmh			rificate of		Re	g. No.		
П	Physician	Decedent's Neme (First, Middla, La					2. Dete of Deat Month	Day	Yaar	I. Tima of Death
5	/Medical	DARRYL E.					IARCH 4	Y		11:00 am
J	Examiner	4a Facility Nama (If not institution, giv WASHINGTON ADV		ITAL	7	4b. City, Town, or Lo		4c. County		
	Funeral Director	5. Social Security Number 6. S 218-80-8695		last birthday)_ Yrs.	If Under 1 Year Montha Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey. AUG 3	Year) 1962	9. Birthplace Country) MARYI	a (Stata or Foreign LAND
	anyland show dust	Usual Rasidence of Decedent 10a. Stata 10b. County Prince	George	ty, Town or Loc						Inaide City Limits 1 X Yes 2 □ No
	or 28s-f s be notified	MARYLAND PRICES	GEORGE FOI	RESTVI	7			000		
	23s or 22s or 7	10e. Street and Number 6455 HIL MAR D	RIVE		10f. Zip Code 20747			0g. Citizen of V US		
21215-0020	ours after death with the Maryla alf, or term 22s or 28e-f shore Examiner must be notified at by Furneral Director	11. Marital Status 12. Viewer Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates:		as Decedent of I Yes, specify Cub ☐ Yas 2 ☑ No	dispanic Origin? (Spe an, Mexican, Puarto Specify:	ocify Yas or No- Rican, atc.)	Blad	e · American I ck, Whita, atc.	
20	ed within 72 hours ygiero. ser than "natural", it, the Medical Exa Completed by	15. Decedent'a Ed (Specify only highest gra	ducation ada completed)	(Giva k	ent's Usual Occup	during most of worki	na	16b. Kind of B	usiness/Indust	ry
2	mble Man	Elementery/Secondary (0-12)	College (1-4or 5+)	lifa. D	O NOT use retire	d)		ETROP	OLITAN	1
		12th	0	CLER	K			OLICE		
and	STORE OF	17. Fathar's Neme (First, Middla, Last)				18. Mother's Name		Aaiden Sumen	na)	
ž	To To	DALLAS E. S		1 461 44 70		BETT			0 7. 0.	4.5
Maryland	S S S S S S S S S S S S S S S S S S S	19a. Informant's Neme/Relationship (end Number or Rura				
सम्बद्ध	Heal I	BETTY SHARPS (M 20a. Method of Disposition	IOTHER)	Place of Disposi	ition (Nama of	R ST. BL		20c. Location		
Baltimore,	Pages ment of ant: If ib lary or o	Parial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specific	Removal from Stata	OSES C	atory or other pla EMETER	7 В,	/11/00	DRURY	, MD.	
Ball	Depart Import any in	21. Signature of Funaral Service Licer	Reese			ess of Fecility E & SONS ST. ANN				
68760,	rificate be executed on physician and set the bunal-transit	Sequentially list conditions, if any, leading to immediata cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (c. ACQUIRA	or as a consequ	ence of):	ARONY A DE	PNA	Euro,	NT A	
. Box	at the death cert d by the attending letached for use of Physician/M	Part II. Other significant conditions of	dontributing to death but not res	sulting in the unc	darivino causa or	ven in Part I.	23b. Did to	bacco use co	ntribute to the	e cause of death?
P.0.	ed by the detached	ANEMIA					1 🗆 Yı	2₽N6	3 Probab	ly 4 Unknown
Vital Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as Completed by Physician/Me						24a. Was a perform		sveiial	autopsy tindings ble prior to letion of cause th?
ř	ysicien: The lav s certificate hes director, page 2 To Be Comp						1 □ Yε	s 2 No	1 🗆 Ye	es 2 No
Ita	entification.	25. Was case refarred to medical axaminar?				26. Place of Deatl	(Check only on	Θ)		
>		1 Yas 2 No	Hospitel: 1 Inpatient 2	ER/Outpatient	3 DOA	her: 4 Nursing Ho	me 5 Reside	ence 8 Oth	er (Specify)	
ouc	After the funeral fune	27. Manner of Death 1 Natural 5 Pending	28a. Deta of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	ry at rk? Yes 2 □ No	28d. Describe ho	ow injury occur	red	
Division of	tal or Attending Physician: rs after death. al Director: After this certification by the funeral director, Certification: To Be (2 Accident invastigation 3 Suicide 6 Could not b 4 Homicide determined	e One Diseased Injury At h	ome, farm, streety)			28f. Location (St. City or Town		per or Rural Re	outa Number,
	hound hound		ysician: To the best of my knowniner: On the basis of axamina							
	within 24 To the Fu	29b. Signature end title of cuit line	and manner atated.		29c. Licens	se number	2	9d. Data signe	d (Month, Day	(, Year)
	6 4 8 4		ATTAND (D)	5 Okha.	1	10011		2/11	2 2007)	
		M Home and My	name alabat constant	7 47174	THE T	217	/	1/4/0	7000	
		30 Name and address of person who	11	983/	Correl	bett Rd.	10.	THAM	MJ.	91911
	State	31. Data filed (Month, Day, Year)	NWAd IUKO 32 Registrar's Signa		ONEEN.	Dell Ita.	WAN	MAM	10,0	10/06
	Registrar	MAR 0 8 200	10 Specia	B.	Donale					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

						d / Depa		Health and f Death		/giene () () (19780
		1. Decedent's Nan	ne (First, Middle, La:	st)					2. Date of D			3. Tima of Death
Physicia	an	Chimlo	Ann C	0.000					Month	Dey	Year	12:30 PM
/Medic	al		y Ann S						March	3 20		12:30 FM
Examin	er	4a Facility Name	(If not institution, give	e street and number)			4b. City, Town, or	Location of Dea	th 4c. County	of Death	
		2572 Be	11 Creek	Drive				Davidso		Anne	Arui	ndel
Funeral		5. Social Security			ge (In yrs.	last birthday)	If Under 1 Yea		8. Date of B	9,1926		place (State or Foreign
Director		213-22-0	779 1	□M 2□XF	73	Yrs.	Months Day	rs Hours Min.	Augus t	9,1926	Mary	land
		Usual Residence	of Decedent									
5 Bu		10e. Stete	10b. County		10c. Cit	y, Town or Lo	cation			I - F-6		10d. Inside City Limits
fer fer	ò	MD	Anne Ar	un de l		David	sonvill	0				1 ☐ Yes 2 ▼No
2 4 4	Directo	10e. Street and Nu		dirder		David				40- 0%	10-11-01-11	-42
with the Marylar a or 25a-f show be notified at	늄						10f. Zip Code			10g. Citizen of V		ntry r
6 2 1	10	2572 Be	11 Creek	Drive			210	35		U	SA	
8 89	Funeral	11. Maritai Status		12. Wes Deceden Armed Forces	Ever in U	,S. 13. V	Vas Decedent of	t Hispanic Origin? (Suben, Mexican, Puer	pecity Yes or N		e - Americk, White,	can indian,
or he	2	1 Never Man	ried 2 Married	1 ☐ Yes 2 🛛					(o i noun, otc.)			OIG.
02	by	3 ₩ Widowed	4 Divorced	If Yes, Give Yeer or Dates			I□Yes 2⊠N	o Specify:		Specify	Whi	te
21215-0020 d within 72 hours at pers. r than "natural, or the Medical Exam	P		15. Decedent's Ed	lucation		16a. Deced	lent's Usual Occ	upation		16b. Kind of Bu		
15	Completed		cify only highest gra	de completed)		(Give	kind of work don OO NOT use reti	e during most of wo	rking			
112	E	Elementary/Sec		College (1-4or	5+)		omemake			Own h	ame.	
			(First, Middle, Last)			11	Omemare		mo /First Middle	a, Maiden Suman		
Maryland 2 should be file h and Mental Hy I a marked othe treturatio event	Be									a, waden Suman	(6)	
New State	2	Jack Wag	ner					Paulin	e Crum			
and and		19a. Informant's N	leme/Reletionship (7	Type, Print)		19b. Meilin	g Address (Stre	et and Number or R	ural Route Numi	ber, City or Town,	Stete, Zij	Code)
E = 81 +		Benjamin	F. Sear,	III / Son		3655	Crane R	oad Por	t Repub	lic, MD.	206	576
other to		20a. Method of Dis	sposition			Place of Dispos	sition (Name of natory or other p		Date	20c. Location -	City or To	own, Stata
			Cremation 3		9		1n Crem		-6-00	Para an trans		Carrell and
	-		5 Other (Specify		FL.						-	Maryland
Balt pemit. Departr Importa		21. Signature of F	uneral Service Licen	500	9	22	. Name and Add	ress of Facility Jo	nn M. Ta	aylor Fu	nera]	Home, Inc.
m 00540		10	Sum	Vousel		14	7 Duke	of Glouce	ster St	Annapo	lis.	MD 21401
		23a. Part 1. Enter	the disease, or comp	plicetions thet ceuse	d the deat						1	Approximate Interval Between
Physician /Medical		Immediete Cause disease or conditi	on	ART	eri	o SCA	Perax	Pic VAS	culo	DIF	mi	Onset and Death
Examiner		resulting in death)		8	Due to (c	or as-a conseq	uence of):	- 1				
	Je.			1/11	o Ro	Von	mo	Ol. KN	1		1	
uted ansit	直	Description and		b	Dun to in		uence of):	eus-	1			
60, be executed ician and burial-transit	Examiner	Sequentially list or if any, leading to it cause. Enter Und	mmediate	1/1	1. DA	Ven	C . 1					
	Cal	Cause (Disease of that initiated event	r injury	· AY	rue	101	SIMS				1	
BOX 687 death certificate e attending phys d for use as the		resulting in death)		11	Due to (o	r as e consequ	uence of):					
ing ing	Physician/Med			4							į	
Box auth cert for use	an			0	- 1							
O. E dea	2	Part II. Other aigni	ificant conditions of	ontributing to death	but not res	ulting in the ur	nderlying cause	given in Pert I.	23b. Dic	tobacco uaa co	ntributa t	o the cause of death?
# 70 m	Å.								1	Yaa 2 No	3 □ Pro	bably 4 Unknown
S, P es that igned b	by P											
Records, he law requires to has been signed as a should be done to he as a should be done as a should be d									24a. Wa	s an autopsy	24b. W	ere autopsy findings
Cord	ete									formed?	81	vailable prior to
Rec e law has b	٥									/	of	death?
The I	Completed								1□	Yes 2 No	1:	☐ Yes 2☐ No
Vital I		25. Was case refe	rred to medical					26. Place of De	ath (Check only	one)		
Vital sloten: The certificate	0 0	examiner?		Hospital:	O -	CO/Outration	4 2 DO4 (Wher:	/		a. (Cana)	4.1
The state of	-	27. Manner of Dea		1 ☐ inpat		28b. Time of	3 DUA	4 U Nursing r	7	how injury occur		77/
On Oil	5	1 Natural	5 Pending	28a. Dete of Inj (Month, D	ay Year)	Injury	28c. In		200. 2000100	Thom injury occus		
Division to Attending after death. Director: After d in by the lune	Cat	2 ☐ Accident 3 ☐ Suicide	investigation					Yes 2 No				
Division or Attendate death Director.		4 Homicide	determined	28e. Plece of Ir building, e	ijury - At he	ome, ferm, stre	eet, fectory, offic	ce ce	28f. Location City or To	(Street and Numbown, State)	er or Rur	al Route Number,
Dia attende	Certification:		,					•				
nepit neri		29a. Certifier	1 Certifying Phy	ysician: To the best	of my kno	wiedge, deeth	occurred at the	time, date and place	and due to the	e cause(s) and ma	nner es	stated.
To the Hospital or within 24 hours at To the Funeral Di completely filled is	edical	(Check only one)	2 Medicai Exam	ilner: On the basis of and manner s	of examine tated.	tion and/or inv	estigation, in my	y opinion, deeth occi	urred et the time	, dete and place,	and due t	o the cause(s)
om the comp		29b. Signeture and	d title of certifier	10/	1	1	29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)
F 3 F 8		16//-	00-1.11	NN	101	1.6	1 0	0000		3-6	-	000
		11/9	reacy	11 /	al	19	U	08293	>	2-7	~	000
		30. Name and add	ress of person who d	completed cause of	death (Iten	1 23a) Type, I						
			Hislop, M	2.1	- 1 4	son Ro		verna Parl	. MTN	21146		

Registrar

State

MAR 0 8 2000

Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) Hildur Sigrid Shatinsky 2. Date of Death 3. Time of Death 26, 2000 Month **Physician** 10:10 pm February /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Arnold Futurecare - Chesapeake If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Hours 1□ M 2⊠ F Yes. 79 041-18-7589 June 8, 1920 New York Director Usual Residence of Deceden death with the Manyland Phow 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits "natural", or Itama 23a or 28a-f ahor Arnold 1 ☐ Yes 2 X No MD Director Anne Arundel 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1251 Dogwood Road USA 21012 Funeral 14. Rece - American Indian Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status be filed within 72 hours after do that Hyglene.
d other than "natural", or flem event, or Medical Examinant. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1949. Baltimore, Maryland 21215-0020 White 1 Yes 2 No Specify: Specify: à 3 ☑ Widowed 4 ☐ Divorced 1952 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeping Secretary 18. Mother's Nema (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middle, Last) 80 Pages 1 and 2 should be nent of Health and Mental le marked Arton Lindstrom Ellen Erikson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra 6009 Woodland Lane, Clinton, MD 20735 Marie Howard/ daughter 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or page. Arlington National Cem. Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 2000 ature of Pyrneral S Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, e. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical week Immediata Cause (Final meumonia disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) 685 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown demention Records. 2 24b. Ware sutopsy findings avsilable prior to complation of causa of death? 248. Was en autopsy performed? Completed page 2 1 Yea 2 No of Vital or Attending Physicisn: Be 25. Was case refarred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 1 (Natural 28d. Describe how injury occurred 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: After Division 5 Pending investigation a after design After Director: After 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by 4 Homicide 1[Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end mannar as ststed.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cadil D-56725 rson who completed cause of death (Item 23a) (Type, Print) 479 Jumpers Hole Rd Severna Park MD tennifer Riedinger MD 21146 31. Data filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 2000

Registrar **DHMH 16 Rev 6/95**

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nema (First, Middla, Last) 3. Time of Deeth Month Vaer SAMS ELSIE Meade 12:00 p.m 2000 4c. County of Death 4e Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 8. Date of Bight (Month, Day, Aug. 20, he Johns Social Security Number ALTIMUE If Under 24 Hrs. 8. SPITAL birthday If Under 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Deys Months Hours 1□M 2√2F 217-26-3403 68 Maryland Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Annapolis 10f. Zio Code 10g. Citizen of What Country? 1104 Tyler Avenue 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes:

1 ☐ Yas 2 No Specify:

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name end Address of Fecility

20b. Place of Disposition (Name of cemetery, cremetery or other place)

Hillcrest Cemetery

. Bronchoalveolar carcinoma

Due to (or es a consequence of):

Due to (or as a consequence of):

Due to (or as e consequence of):

obstructive pulmonors

Contracting Officer

1104 Tyler Ave. Annapolis, Md. 21403

White

Approximate Interval Between Onset and Death

Twenty eight

3 Probably 4 Unknown

24b. Were autopsy findings svailable prior to

completion of cause of death?

1 ☐ Yas 2 ☐ No

VEACS

Federal Government

16b. Kind of Business/Industry

20c. Location - City or Town, Stete

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No

2 0 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Day, Year)

March eighth Low

24a. Was an autopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

03-11-00 Annapolis, Maryland

John M. Taylor Funeral Home, Inc.

18. Mother's Name (First, Middle, Maiden Sumeme)

Frances O. Bowen

147 Duke of Gloucester Street Annapolis, Md. 21401

19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

Berns 23s or 25s-f 72 hours after "natural", or altimore, Maryland 21215-0020 Hyglene. 8 and Mental Is marked Pages 1 and 2 should important: If Item 27 I. any injury or other tre-Health

Physician

/Medical

Examiner

10a State

Maryland

Funeral

Director

Physician /Medical Examine

that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

\$

signed I

Be Examiner Physician/Medical p Completed Be 1 Yes 2 No Certification: To 27. Menner of Death 1 (Netural 2 Accident 3 Suicide 4 Homicide 29e. Certifier Medical

within 24 hours aft To the Funeral Di completely filled in

Directo 10a Street and Number Funeral 11. Marital Status 1 Nevar Married 2 Married Àq 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondery (0-12) 12 17. Father's Neme (First Middle Last) Brooke A. Meade 19e. Informent's Neme/Reletionship (Type, Print) George Louis Sams/ Husband 20a. Method of Disposition ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service License 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was casa referred to medical examiner?

Kerhani Salomen 31. Date filed (Month, Day, Ye State Registrar AR 1 0 2000

29b. Signatil

INTERN 30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print)

1 Mnpatient

28a. Dete of Injury (Month, Day Year)

Hospitel:

5 Pending

re and title of certif

investigetion

6 Could not be

College (1-4or 5+)

Chronic

GOI North caroline street Bultimure Maryland

2 ER/Outpatient 3 DOA

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work?

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. Licanse number

1 Yes 2 No

32. Registrer's Signature

DHMH 16 Rev 6/95

MAR I O 2000 Draw D. Assale

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death :20 AM of Deeth 4b. City, Town, or Location If Under 1 Year 8. Dete of Birth (Month, Day, Sept. 17, Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 1 M 2 F Months Days Hours Min. 370-03-1473 82 Maryland Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis 10f. Zlp Code 10e Street and Number 10g. Citizen of What Country? 721 Harness Creek View Drive 21403 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩∏ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Merried 1□Yes 2♥ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Commercial Photography Photography 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) James William Scott Lillian Kopp 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merle Scott/ Wife 721 Harness Creek View Drive Annapolis, Md. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 03-10-00 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Fuperal Service Licens John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of). 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to 24e. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 M No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examine Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 112 Natural 5 Pending

Physician /Medical Examiner

Physician

'- /Medical

Examiner

10a State

Director

Funerai

by

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

with the Marylenc

72 hours efter death

d 2 should be filed within 72 h end Mentel Hygiene.

permit. Pages 1 and 2 st Department of Health end Important: If item 27 is m

other

6

any Injury

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai

attending physician and for use as the burial-transit certificate be execu Box 68760 P.O. the signed by the Records, page 2 certificate hes Division of Vital director, funeral al or Attending P safter death.

I Director: After I After à To the Hospital within 24 hours 4 To the Funeral L

by Completed Be P

Certification: 2 Accident 3 Suicide 4 Homicide 29a. Certifier edical (Check only one)

29b. Signatu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

investigation

Could not be determined

1 Yes

2 No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

JEFFREY BRIGGS, MD

31. Dete filed (Month, Day,

MAR 1 0

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

with the

10

þ

Completed

Be

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Capitol Heights

Yrs.

10c. City, Town or Location

Months

Days

HAYWARD STARKS	State of Maryland / Department of Health and Mental	Hygiene []
end item 23a,b,c,d,27 per me 3/27/00 yg		Reg. No.

17

	0	7	0	1
0	7	1	Ü	11

3. Time of Death

18:53

Birthplace (State or Foreign Country)

10d. Insida City Limits

1 ¥Yes 2 No

Physician /Medical Examiner **Funeral** Director the Maryland ahow. Directo notifie b 228 Funeral thems: 72 hours shar Baltimore, Maryland 21215-0020 "natural", or

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mantal Hy important: if Nem 27 is marked othe any Injury or other treumatic svent about

Physician

/Medical

Examiner

physician and the burial-transit

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After

within 24 hours after death To the Funeral Director: , completely filled in by the

To the Vithin 2

Hospital

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the death certificate be axecuted

Box 68760

P.O.

Records.

Division of VItal or Attanding Physician: Examiner

Physician/Medical

by

Completed

8

Certification: To

edical

am

Usual Residence of Decedent 10a. State 10b. County Maryland | Prince George's 10e Street and Number 812 Alabaster Court

1. Decedent's Name (First, Middle, Last)

4a Facility Name (If not institution, give street and number)

PRINCE GEORGE'S HOSPITAL CENTER

STARKS, III

6. Sex 1 M 2 □ F

HAYWARD

5. Social Security Number

579-13-4340

11 Marital Status 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed)

10f. Zip Code 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 1 Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

20743

Sales Representative

14. Race - Amarican Indian, Black, White, etc. Black. Specify. 16b. Kind of Business/Industry

PRINCE GEORGE'S

Maryland

Elementary/Secondary (0-12) 11th 17. Father's Name (First, Middle, Last) Hayward Starks, Jr.

18 Mother's Name (First Middle, Maiden Surname) Florence Woodson

19a. Informant's Name/Relationship (Type, Print) Florence Jackson/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 Alabaster Court, Capitol Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) Deta 03/18

2000

2. Date of Death

Month

4b. City, Town, or Location of Death

CHEVERLY

Hours

Day

4c. County of Death

10g. Citizen of What Country?

U.S.A.

MARCH 14, 2000

8. Date of Birth (Month, Day, Year) March 16, 1982

20a. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses

Ft. Lincoln Cemetery

Brentwood, Maryland

20c. Location - City or Town, Stata

Vance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture list only one cause on each line.

J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

BRONCHOPNELMONIA

College (1-4or 5+)

Due to (or as a consequence of)

HYPOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

CARDIAC ARRHYIHMIA

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Due to (or as a consequence of):

ANOMALOUS RIGHT CORONARY ARIERY

23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

Yes 2 No

25. Was case referred to medical examiner? 1 No Yes 2 No 27. Manner of Death

5 Pending investigation 1 (2(Natural 2 Accident 3 Suicide

28a. Date of Injury (Month, Day Year) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of partifier

O.C.M.E.

29c. License number

MARCH 15,2000

30. Name and address of person who completed cause of death (Item 23s) (Type, Print)

JACK MW MI 31. Date filed (Month, Day, Year)
MAR 2 0 2000

111 Penn Street, Baltimore, Maryland 21201

State Registrar

P. Registrar's Signature

1005年第11日 1005年第11日

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decours a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Vear SULLIVAN 4c. County of Death GORDON 5:01 pm MARCH 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death BAUTIMORE BALTIMORE VETERAN'S HOSPITAL BALTIMORE CITY 7. Age (In yrs. lest birthdey) | ff Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Months | Davs | Hours | Min. (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) 1**⊠** M 2□ F Months Days Hours 71 Yrs. 4/9/1928 219-22-2683 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Sussex Millsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Putting Way 19966 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian 11. Marital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: Navy 1 Never Married 2 Merried 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorcad 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Military U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Monroe Sullivan Freida Miller 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jennifer Sullivan (wife) 19 Putting Way, Millsboro, DE 19966 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 3/10/00 Salisbury, MD 21. Signature of Funeral Servica Lieensee 22. Name and Address of Fecility Holloway Funeral Home, P.A.
501 Snow Hill Rd., Salisbury, MD 21804
shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Apprix 2 mo. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown aspiration preumonia 24b. Were autopsy findings avellable prior to completion of cause of death? 24a. Was an autopsy appro-bifemoral bypass surgery. 1 ☐ Yes > No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of 27 Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basia of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Examiner Records, P.O. Division of Vital

physicien end the buriel-transit es i esn esn ed by the deteched signed by t certificate hes funeral After death. or Attended efter death Director: Hospital 24 hours To the Hosp within 24 hor To the Fune completely fi

Examiner Physician/Medical λq Completed Be To

Physician

· /Medical

Examiner

Funeral

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28a-f show

Director

Funeral

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner traum be notified at

d 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "ru

permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 Is m any Injury or other traum once.

Physician /Medical

the Maryland

death

Maryland 21215-0020

Saltimore.

Registrar

Medical

29b. Signature and tipe of certifier uma

M.D.

29c. License number P12502 29d. Date signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) M.D.

of Maryland Medical Center

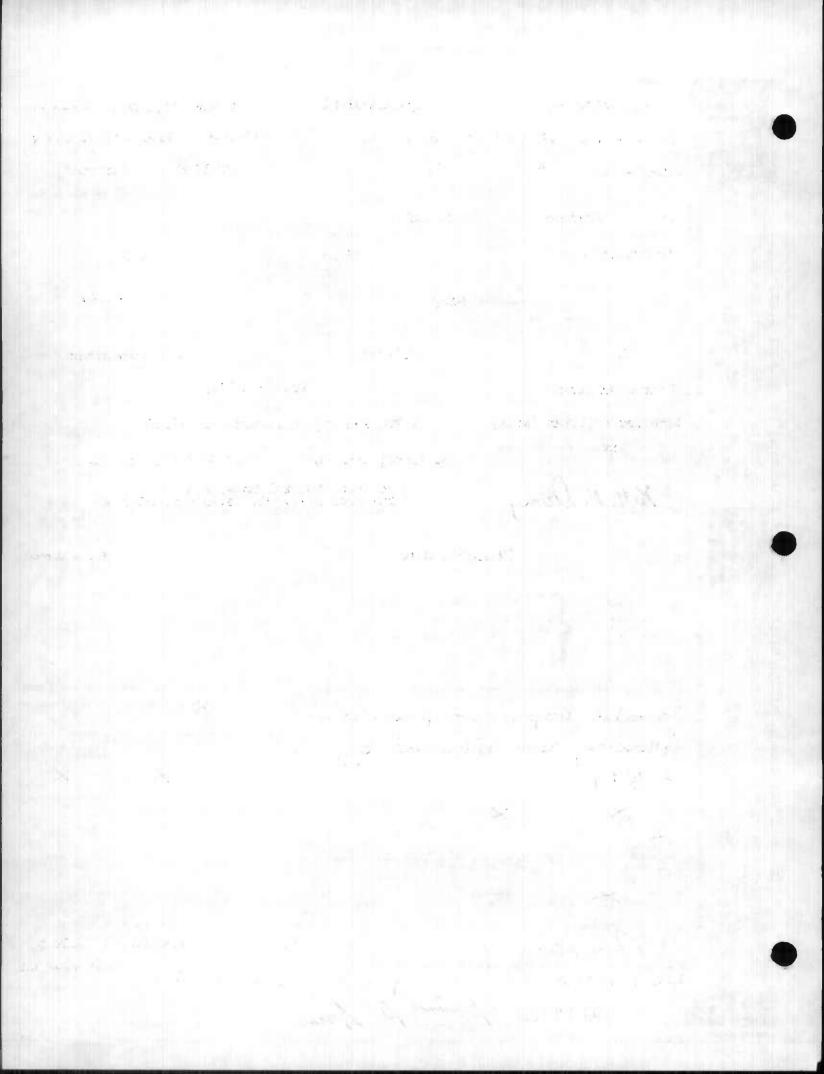
MARCH, 9, 2000. Baltimore, MD

31. Date filed (Month, Dey, Year) MAR 13 2000

LALIT VERMA

32. Registrar's Signature

University



Piease Type or Print in Biack indelibie Ink. Assure Aii Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death HELEN SCHMIDT SADLER March 5,2000 4:05 AM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 30360 Maple St., #305 Princess Anne Somerset 5. Social Security Number tf Under 1 Yeer | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) October 14,1921 Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) Months Days Hours 1□M 2□F 212-18-3755 Yrs. 78 Maryland Usual Rasidance of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 30360 Maple St. #305 21853 USA 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Never Merried 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Dates: 1 Yas 2K No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maiden Surname) Leon Schmidt Agnes Mieleski 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Sheri Gauer/Daughter 21843 Crisfield-Marion Rd., Marion Station, MD 21838 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Removel from Stata St. Stanisiaus Cemetery 3/10/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funaral Sarvice Licensee 22. Name and Addrass of Facility MOIDSI Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximata Interval Between Onset and Death PNEUMONIA Immediate Cause (Final diseasa or condition rasulting in daath) 7 Days Due to (or as a consequanca of): SEVERE COPD Dua to (or as a consequance of): Dua to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Ca. LUNG. 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy

Physician /Medical Examiner

bengis d be det

page 2 ;

certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifical stely filled in by the funeral director.

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

certificate be axecuted physician and

Box 68760.

P.O. 1

Records.

Division of Vital

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

permit. Pages 1 and 2 should be i Department of Health and Mental i Important: If Nem 27 is marked of any injury or other traumatic eve

Physician

/Medical

Examiner

Directo

Funeral

Funeral

Director

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Berns 23s

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Maryland 21215-0020

altimore,

Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last

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Other aignificant conditions of	ontributing to death but not rasulting in the underlying causa givan in Part I.

1 Yes 2 No

1 T Yes 2 No 25. Was case refarred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 PAssidence 6 Other (Specify) 1 Yas 2000 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending 1 Yes 2 No 2 Accidant invastigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida

29e.	Cartifier
	(Check only
	one)

1 Certifying Phyalcian: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura end titla of certifiar

29c. License number

29d. Date signed (Month, Day, Year)

Jugury worndag

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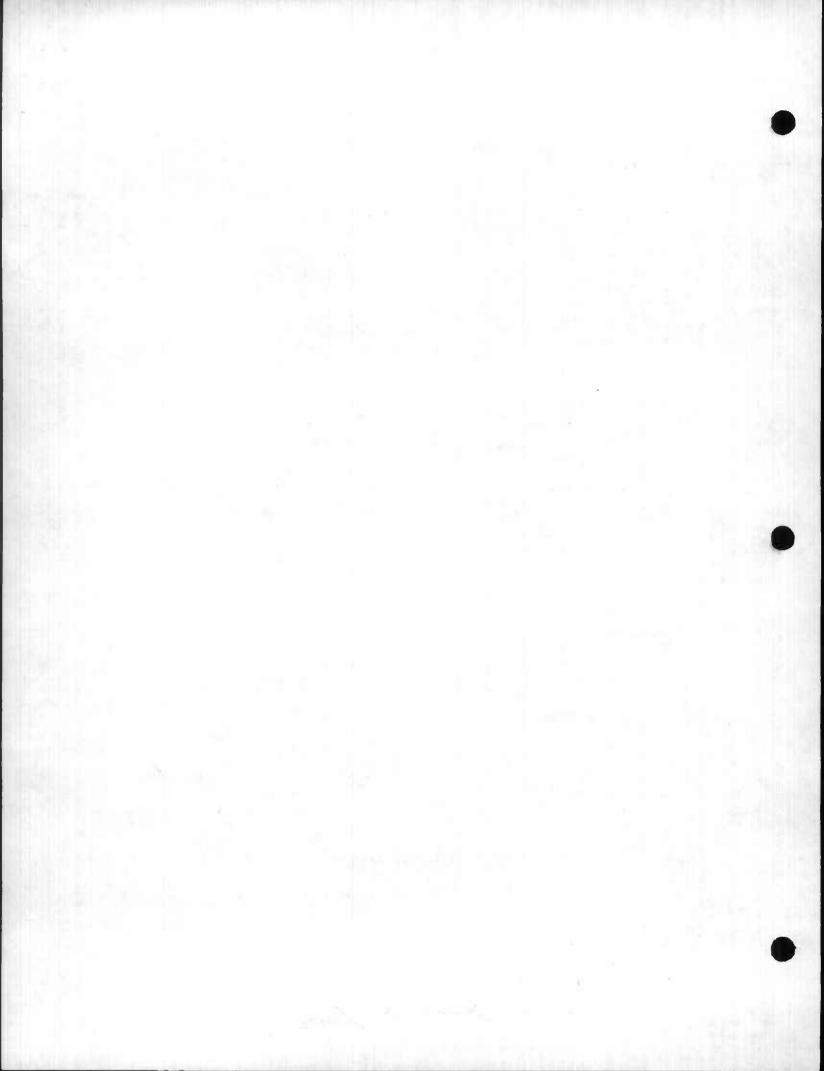
30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

MAHESH MOUNDRA 106 MILPORD ST SOUB SAlisBURY UND 2-1804 31. Date filed (Month, Day, Year)

State Registrar

MAR 0 7 2000





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death March 5,2000 **Physician** KENNETH LEE SWISHER 11:46 PM /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 722 Ahchor Chain Unit 1 Ocean City Worcester If Under 1 Yaar Months Days If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Director 234-52-9602 66 August 28,1933 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Director Ocean City Maryland Worcester 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Rema 23s or 722 Anchor Chain Unit 1 21842 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 Never Married 2 Married 1 N Yes 2 No
If Yes, Give
Year or Detas: Army altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 4 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Police Security 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 88 Pages 1 and 2 should be nent of Health and Mental is marked Harlin Eldin Swisher Garnet Pauline Thompson 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if them 27 is any injury or other trau Grace F. Swisher/Wife 722 Anchor Cahin Unit 1, Ocean City, MD 21842 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20a Method of Disposition Date 20c. Location - City or Town, Stete 1 DBurial 2 Cremetion 3 Removel from State Maryland Veterans Cemetery 3/8/00 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD 22. Name and Address of Facility
Holloway Funeral Home Porfessional Association 21. Signeture of Funerat Service Licenses Keell 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or heart feilure. List only one gause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical tmmediate Cause (Finel disease or condition resulting in death) ~8 Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or es e consequence ot): physician street Records, P.O. Box 68760, Physician/Medical Dua to (or es a consequence ot): signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to complation of causa of death? Completed 24e. Was an autopsy performed? phoods page 2 has 1 Yas 1 Yes 2016 certificate Division of Vital or Attending Physician: funeral director, 25. Was cese referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? After 5 Pending investigation Natural 1 Yes 2 No 24 hours after death. 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Certifier completely (Check only one) within 2 \$ 29b Signature and little of certific 29c. Licansa number

State Registrar

DHMH 16 Rev 6/95

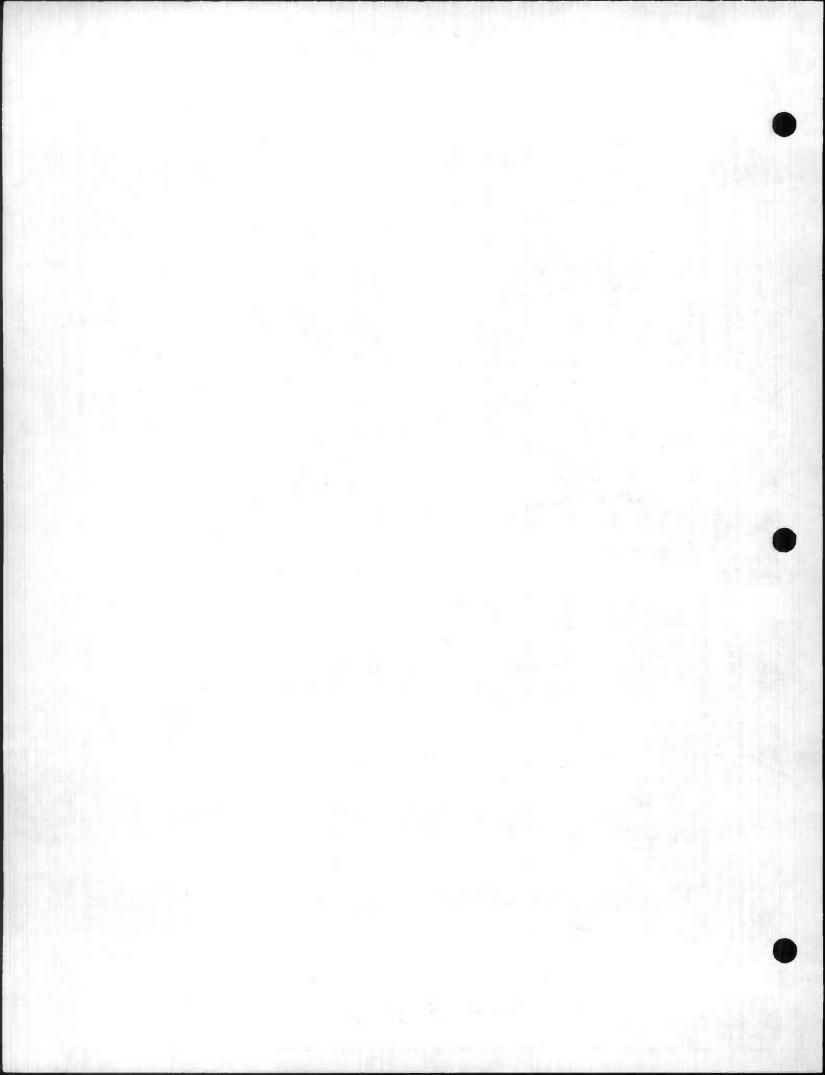
Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signeture

62sa/1

Date filed (Month, Day, Year) MAR 0 8 2000



Physician	
/Medical	
Examiner	

Funeral Director

the Maryland or 28a-f show Directo with "natural", or items 23a or Funeral 72 hours efter death by r than 'natur Completed permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "n any Injury or other traumatic event, the Med once. **Physician** /Medical Examiner Examiner physician and the buriel-transit The law requires that the death certificate be executed Records, P.O. Box 68760. Physician/Medical 80 use signed by the e Completed by After this certificate has funeral director, page 2 Division of Vital or Attending Physician: efter death. Be Certification: To Director: A within 24 hours efter To the Funeral Oire completely filled in b edical 30. Nama end address of person was completed cause of death (Item 23a) (Type, Print) 3 Robert 31. Dete tiled (Month, Day, Year) FEB 2 9 2000 32.

1. Decedant's Name (First, Middle, Last) 2. Deta of Daath 3. Time of Death Day Month FEBRUARY 29,2000 NORMAN W. SHORES, SR 2:10 A.M. 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 7890 DUBLIN RD SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₩ M 2□ F Yrs. 70 MAY 5, 1929 218-20-7774 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2√ No MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 819 WILLIAM ST 21804 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Yeer or Detes: 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced WHITE 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 6 OWNER MOVING & STORAGE 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LEE ANDREW SHORES MARY FRANCES MESSICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NORMAN W. SHORES, JR 7890 DUBLIN RD SALISBURY, MD 21801 20b. Pleca of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL MEMORY GARDENS 3/3/00 HEBRON, MARYLAND 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee 705 E. MAIN ST. SALISBURY, MD 21804 BOUNDS FUNERAL HOME, INC. 23e. Part1. Enter the disaasa, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart tailura. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death) Cerebrounsalon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1) Yee 2 No 3 Probably 4 Unknown I Diabetes mellitus 24b. Were autopsy tindings available prior to completion of cause ot death? 24a. Was an autopsy Hyperlipidemia 1 ☐ Yes 2 NONo 1 ☐ Yes 2 No 25. Was case reterrad to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Daturai 2 Accidant 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of

DZ4986

560 Riverside Dr. Salisbury Md. 21801

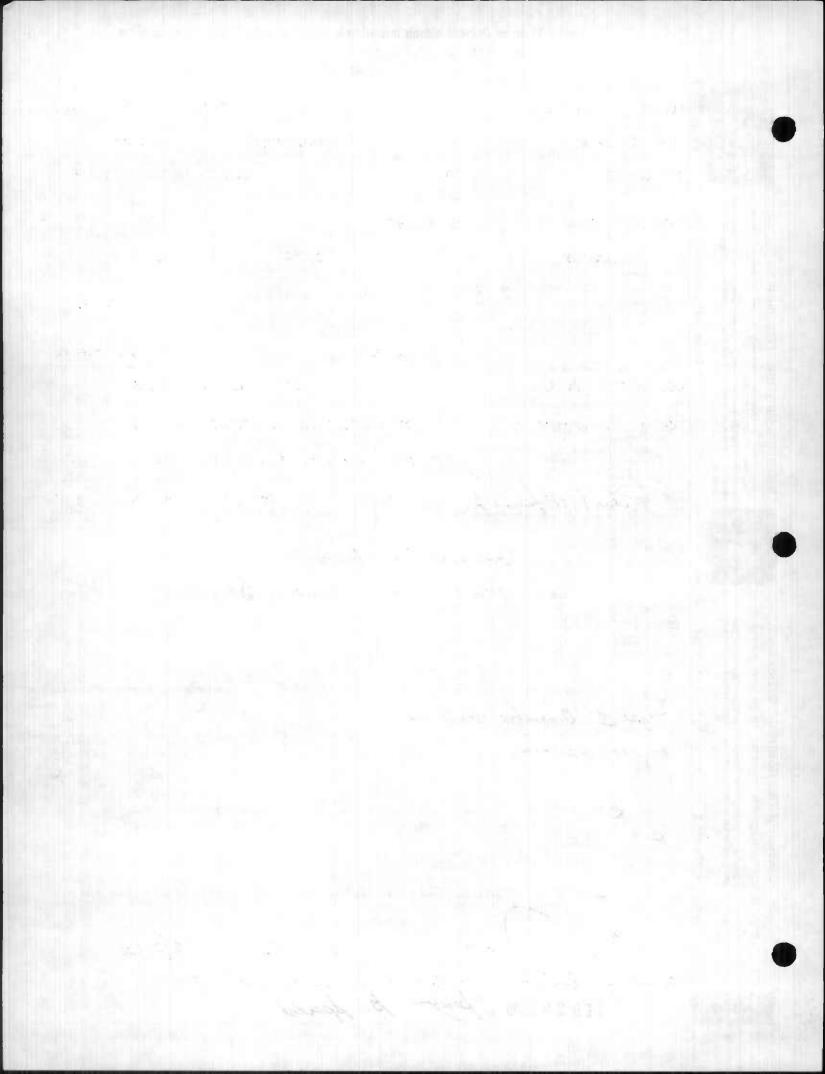
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32. Registra/s Signature

Reilly

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State Registrar



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with the Marylan

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"natural", or flams 23s or 28s-f The Medical Examiner must be notifi-

Hygiene.

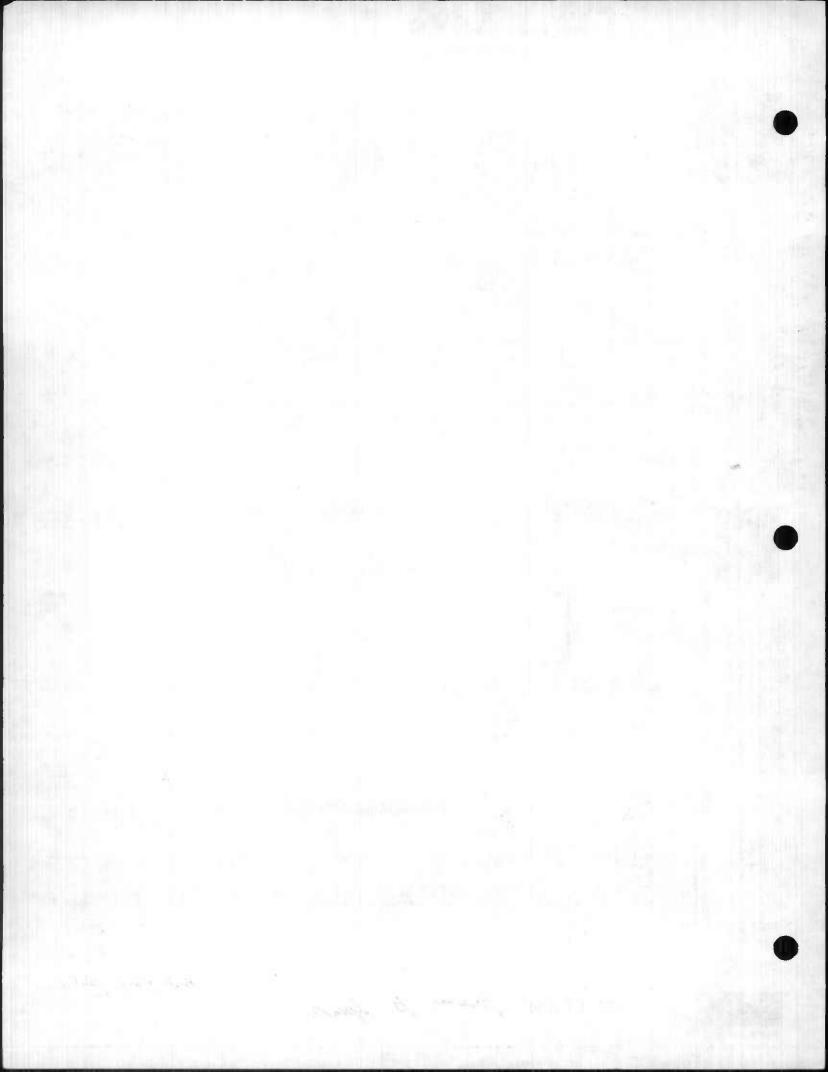
Department of Health and Mental Hygh Important: if Nem 27 is marked other any Injury or other trauments

	11.	
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be asscuted within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Year **Physician** Ebywary 13, 200 a tion of Death 4c. County of Death Raymond T. Strick 1325 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 F 9. Birthplace (State or Foreign Country)

Kansas 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 6-14-1917 **Funeral** Days Months Hours 493-12-5818 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes No Directo Sussex Delmar 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? Rt.#1 Box 478 19940 USA Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White If Yes, Give Year or Dates: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) minister Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Strick Clara Frechenski Strick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorine Strick, Wife Rt. 1 Box 478 Delmar, De. 19940 20a. Method of Disposition 20b. Placa of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, State NBuriaf 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 2-17-00 Georgetown, De. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each area. Approximate Interval Between Onset end Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) Obstructive Examiner Due to (or as a consequence of) Examiner PV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nemic Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown g 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 8 26. Place of Death (Check only ona) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 29a. Certifier niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical Exa 29b. Signature and fille of conflict 29c. License number 29d. Date signed (Month, Day, Year) 10054127 mo 30. Nama and address of perspn who completed cause of death (Item 23a) (Type, Print) Alon Davis, m.D. God 21875 Delmar B1500 31. Date filed (Month. 32. Registrar's Signature State 2000 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

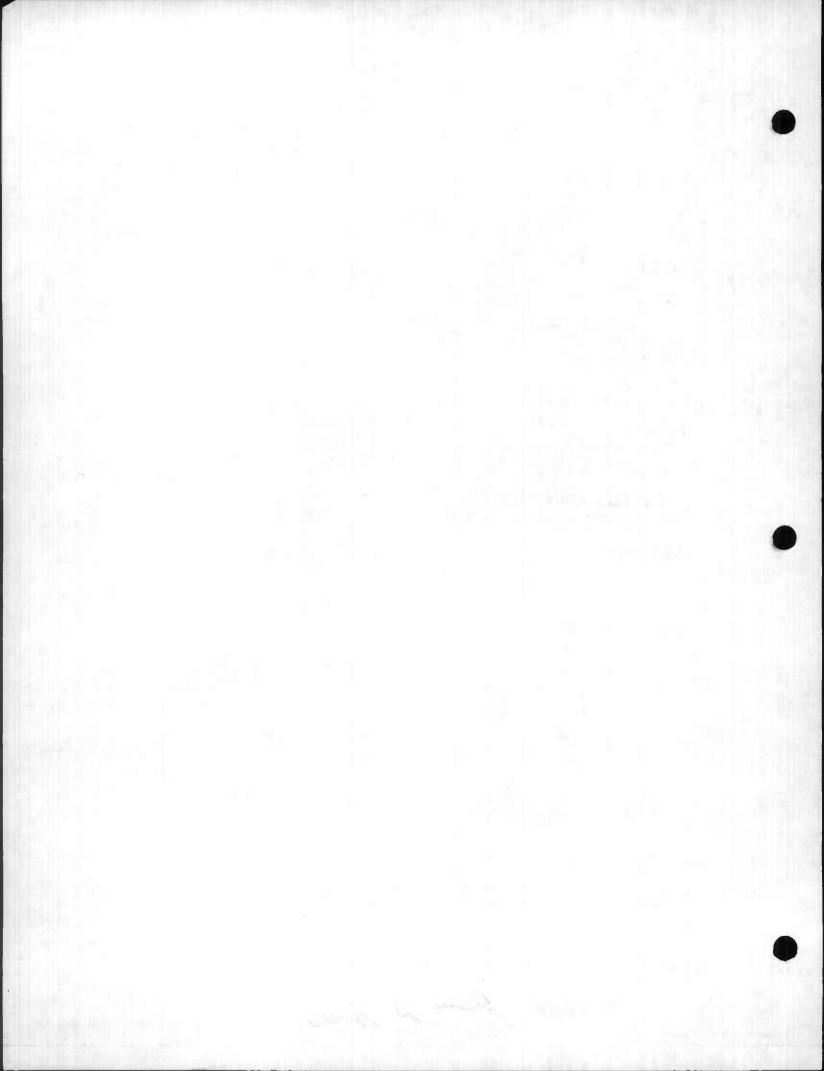
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** LUCILLE SCOTT FEBRUARY 14, 2000 0220 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death WICOMICO Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER 8. Date of Birth (Month, Day, Year) ADT. 21, 1918 If Under 1 Year If Under 24 Hrs. Birthplace (Stata or Foreign Country)
 Florida 5. Sociat Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days 1 M 2 XF 81 Yrs 160-24-5187 **Director** Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Herrs 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral US Rt. 50 & Civic Avenue 21804 USA 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. hours after 1 Yas 2 No If Yas, Giva Year or Datas: 1 Never Married 2 Married b 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry 2121 filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th housewife domestic Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Mental James George Washington Florence Hayward and a 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Nem 27 is any injury or other tra Ruby T. Collins/granddaughter 17263 Hayward Road - Pocomoke, Maryland 21851 altimore, 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) MD Veteran's Cemetery 2/22/00 Hurlock, Maryland 22. Nama and Address of Facility 1213 Jersey Road - Salisbury, 21. Signature of Funeral Sarvice Licens JOLLEY MEMORIAL CHAPEL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition rasulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760, physiclan Physician/Medical the the Dua to (or as a consequence of): P.O. Part It. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detec 1 ☐ Yes ZX No 3 Probably 4 Unknown mellitus Division of Vital Records. p 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No certificate Attending Physician: 25. Was casa refarred to medicat director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturat 5 Pending death. 1 Yes 2 No ie Hospital or Attendir n 24 hours after death, ne Funeral Director: Al pletely filled in by the fu 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifian 15384 odney a. Wemich, m. D 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21804 RODNET 100 POWER ST. SALISBURY WENRICH 31. Date filed (Month, Day, Year) FEB 1 8 2000 32. Registrar's Signatura State

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended #5/2-24-2000/WCHD/HLC 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth **Physician** Month Yaai JOHN WILLIAM SEWARD, JR 02 19 00 2035 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SALISBURY
If Under 24 Prs. 8. Deta of Birth
Min. (Month, Day, Year) 6822 EDWARDS AVE WICOMICO If Undar 1 Year Birthpleca (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Deys **X** M 2□ F Yrs Director 30 June 24,1969 Maryland Usual Residence of Dacadeni the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limits 28a-f show il Hygiene. other than "natural", or frems 23a or 28a-f show vent, me Medical Examiner must be molified at Wicomico Maryland Salisbury 1 ☐ Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 6822 Edwards Ave. 21804 USA Funeral filed within 72 hours after death 12. Was Decadent Evar in U,S Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Raca - Amarican Indian, Black, White, etc. 1 ☐ Never Merriad 2 Married 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Datas: 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Auto Painter Automotive Repair 8 traumatic svent. Maryland 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Melden Sumama) Be Pages 1 and 2 should be family of Health end Mentel I nt: If Nem 27 Is marked of John William Seward Sr. Madeline Mae Massey 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Seward/Wife 6822 Edwards Ave., Salisbury, MD 21804 other Baltimore, If item 20b. Place of Disposition (Name of cemetery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Removal from State permit. Page Department of Important: If any injury or 2/22/00 Springhill Memory Gardens 4 ☐ Donetion 5 ☐ Other (Specify) Hebron, MD of Euneral Service Licenses 22. Name end Addrass of Facility M01051 Holloway Funeral Home Professional Association OUC DOMPOON 501 Snow Hill Rd., Salisbury, MD 21804 23e. Part1. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one causa on aach line. Approximete Intervel Between Onset and Deeth **Physician** Immedieta Ceuse (Final diseesa or condition resulting in death) /Medical **ASPHYXIATION** Examiner Due to (or es e consaquança of): Examiner HANGING (SELF INFLICTED) be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in deeth) Last Due to (or as a consequence of): and Box 68760, physician Physician/Medical thet the death certificate the Due to (or as a consequence of) attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 signed by t 0 1 | Yes 2 No 3 | Probably 4 | Unknown þ Division of Vital Records. The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? peen hes certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case rafarred to medical Be 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1XYes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of After 1 Natural 5 Panding Injury death. 1 Yes 2 No investigation 2 Accident 2-19-00 HUNG HIMSELF or Attend efter death Director: 1030 In by the 3 Suicide 4 ☐ Homicida 6 Could not be 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) WIFE'S HOUSE-6822 EDWARDS AVE 24 hours e SALISBURY, MD. Hospital 21804 edical 29e. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and place, end due to the causa(s) end manner es stated.

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To the Within 2

State Registrar 29b. Signature end title of certifier

JOHN T. BULKELEY, M.D. 106 MILFORD ST. SALISBURY, MARYLAND 31. Data filed (Month, Day, Year) FEB 2 3 2000 32. Ragistrar's Signature

el sue DME

30. Nema and address of parson who complated causa of death (Itam 23a) (Type, Print)

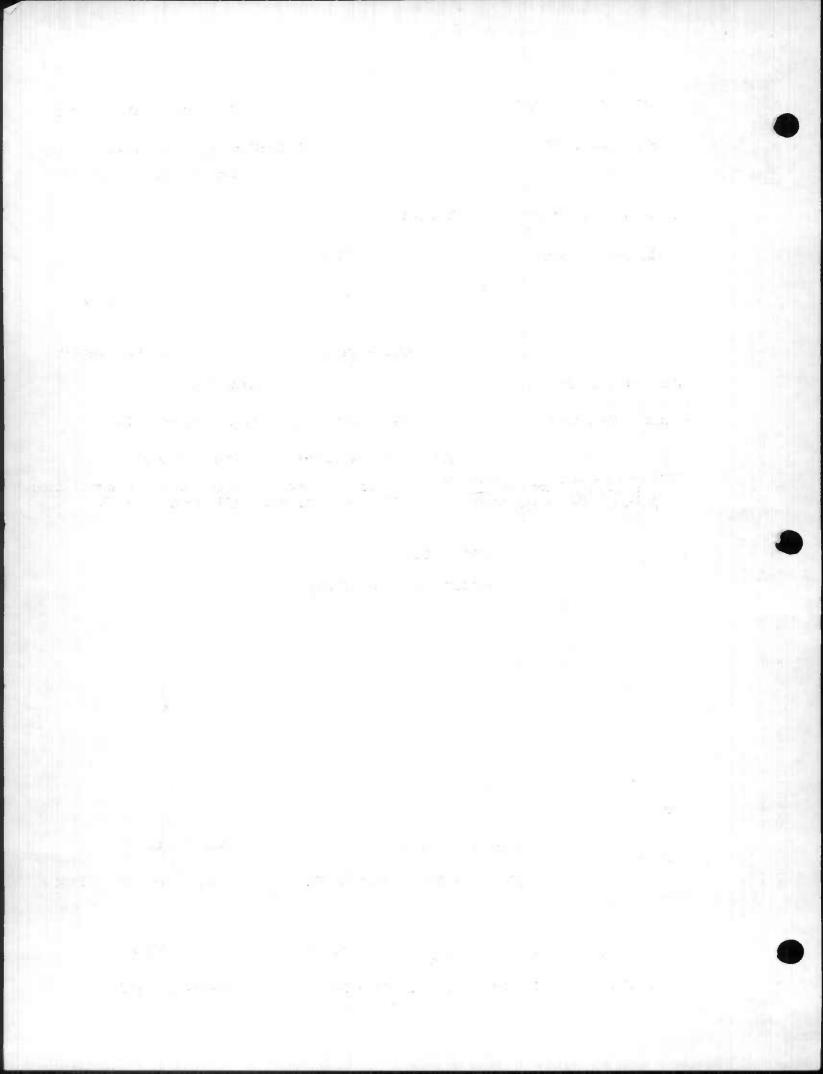
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated.

29c. License number

D0003599

29d. Date signed (Month, Dey, Year)

2-20-00



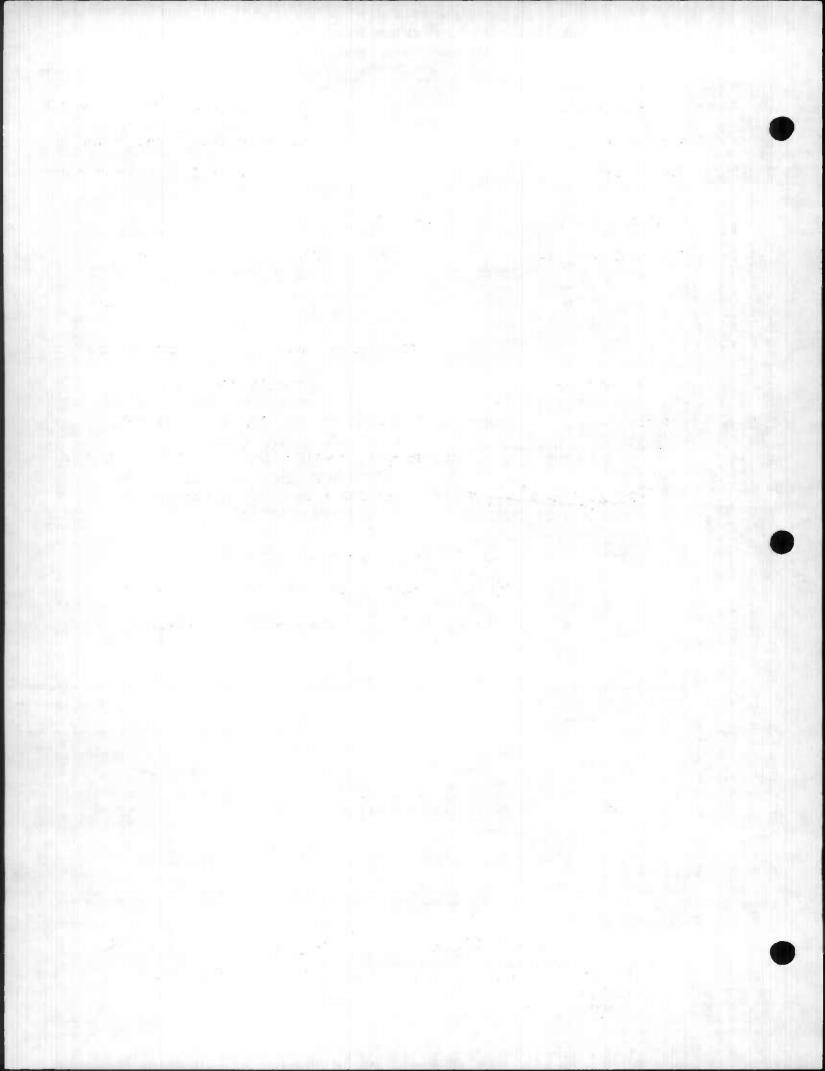
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** March 9, Hazel M. Shorter 2000 5:48 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death **Examiner** Prince George Fort Washington Hospital Fort Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Deys | Hours | Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral Months Deys 1□M 2XF 79 Director 214-30-1578 July 18,1920 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location Hygiene. other than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Inportment if Item 27 is marked other than "natural", or items 23s or 2735 Middletown Road 20603 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 (2) No
It Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: by 3 Widowed 4 □ Divorced Black: Yeer or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cleaning-Residence Self Employed event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 27 is marked or trsumatic ever Ollie Lyles Carrie Lyles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 7532 Bumpy Oak Rd., Laplata, Md. 20646 Kirstin Swan Executor 20b. Place of Disposition (Neme of cametery, cremetory or other place) March 13, 2000 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from Stete à Pomfret, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Josephs Catholic Church 21. Signature of Funeral Service Licensee Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Box 68760 Physician/Medical Due to (d as a consequence of): attending p P.0. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 → triknown Records, by should t 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' iis certificate has t I director, page 2 s 1 ☐ Yes 2 -No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 ANatural 5 Pending investigation Injury death. 1 Yes 2 No Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide n 24 hour. the Funeral Directory Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 To the I end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number use of death (Item 23a) (Type, Print) 30. Name and address of person who completed the 25 0 0 31. Date tiled (Month, Dey, Year) 32. Registrar's Signature State Registrar MAR 14 2000

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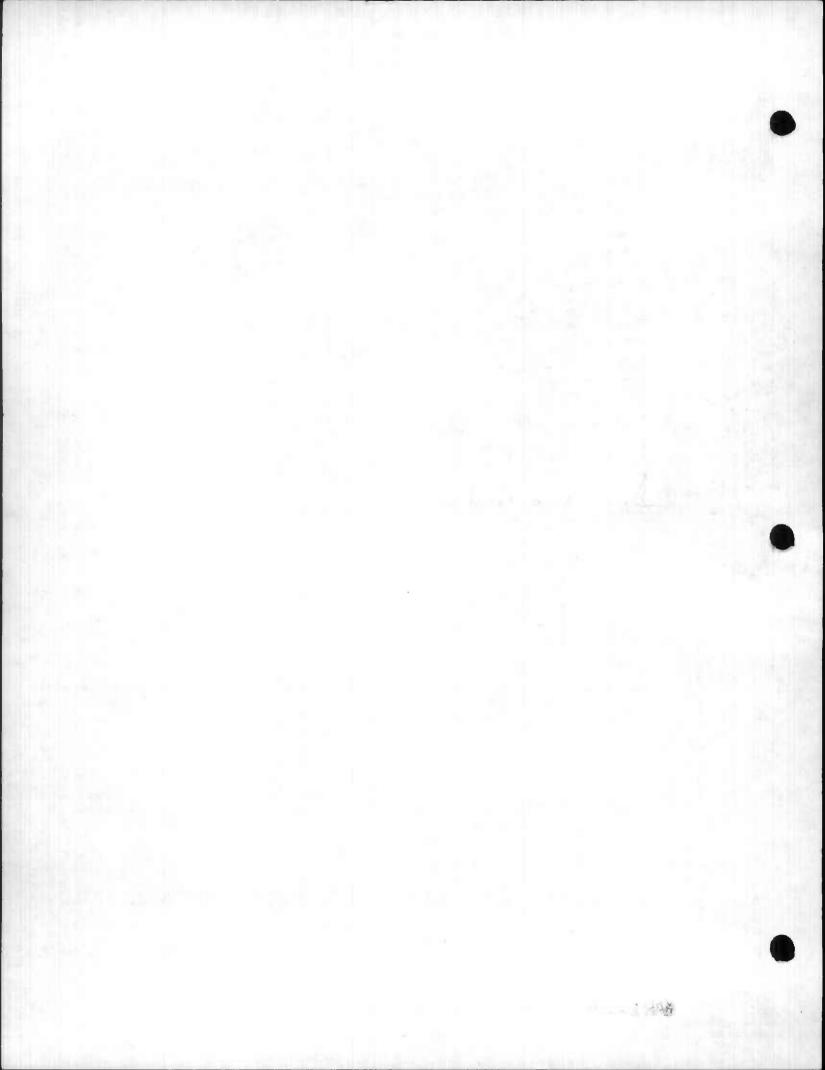


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State of Maryland / Department of Health and Mental Hygiene 0 0 9 7 9 3

			Ce	rtificate o	Death	2. Date of Death	g. No.				
Physician		Decedent's Nama (First, Middle, Last)							of Death		
/Medical	Wilda		Stroud		4b. City, Town, or I	March 12	2 2000 4c. County		5 A		
Examiner			Contain								
Funeral	Calvert Manor 5. Social Security Number 6. Se		In yrs. last birthday)	If Under 1 Yea	Rising ar If Undar 24 Hrs.	8. Date of Birth	Cec	9. Birthplace /State	or Foreign		
Director	1 M 2X F Vrs Months Days Hours Min. (Month, Day, Year)						Country) Maryland				
Bu Bu	10a. Stata 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside 0	City Limits		
120 Its after death with the Marys If, or items 23e or 28e1 sho xerriner must be notified at by Funeral Director	Delaware New Ca		s 2 No								
	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eva Armed Forces? 1 Yas 20 No If Yes, Give Yaar or Datas:		Was Decedent o If Yas, specify Cu 1 ☐ Yes 2 🔯 N	pecify Yas or No- o Rican, etc.)	as or No- etc.) 14. Race - American Indian, Biack, White, etc. Specity: White					
1 Z1Z13-UUZU ed within 72 hours all rgiene. ver then "netural", or k, the Medical Exem Compolated by F	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> Coilege (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	16b. Kind of Business/Industry						
	8		Но	memaker				own home			
S S S S S S S S S S S S S S S S S S S	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	aiden Sumam	9)			
yia Mentantantantantantantantantantantantantan					Anna	A. Watts					
2 sty 2 sty 2 sty 1 mm 1 mm	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Stre	et and Number or Ru	ıral Routa Number,	City or Town,	Stata, Zip Code)			
- 6 2 24 2	William H. Strou				Drive, New						
attimore, mil. Pages 1 a partment of He portant: if Item y Injury or othe		20a. Method of Disposition 1 Burial 2 Tormation 3 Ramoval from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of commetery, crematory or other place) R.A. Ferris & Co., Inc. 3/16/00 West Chester, PA									
and with the state of the state	21. Signature of Funeral Sarvice Licen	500	2	2. Nama and Add	ress of Facility			ester, ra			
D SEES	Hicks Home for Funerals, P.A.										
	23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
Physician /Medical	shock, or heart failure. List only of	Immediate Cause (Final disease or condition as the condit									
Examiner	disease or condition resulting in death)	10 da	10 days								
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he law requires that has been signed by ge 2 should be determined by PI						24a. Was an perform		24b. Wera autopsy available prior completion of	rto		
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certificate rector, page Co	25. Was case referred to medical				26. Place of Dea	ath (Check only one)				
2 00 5	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA	Other: 4 Nursing H	lome 5 ☐ Resider	nce 6 Othe	er (Specify)			
D 4 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		28a. Date of Injury (Month, Day Y	(ear) 28b. Time o	f 28c. In		28d. Describe ho					
ath. Ath	1 Natural 5 Pending 2 Accident investigation	(MOINI, Day 1	our) Injury		Yas 2 No						
bill or Attending P is after death. al Director: Attert led in by the funeri	a Could act be						281. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the tuneral Medical Certification:		sician: To the best of n iner: On the basis of ax and manner stated	amination and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and ma te and place, a	nner as stated. and due to the cause	·(s)		
Me of the	29b. Signature and title of certifier	06/1	,	29c. Lice	nse number	29	d. Data signed	(Month, Day, Year)			
1 1	1 00-0	11.1	P	mo	H005439		arch	13 200	8		
	30. Nama and address of person who o	impleted cause of deat	th (Item 23a) (Type.								
		Sales of Sales and Control	, , , , , , ,								

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decadent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** Russell Samuel Scott 1000 MARCH 4c. County of Deeth /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** PRINCE GENGES BENNETT ANENUE SUITLAND 4811 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Month, Day, Year) March 8, 1920 5. Social Security Number 7. Age (In vrs. last birthday) If Undar 1 Year **Funeral** Days Min Months Hours 79 Yrs. MaryLand Director 579-16-1160 Usual Residence of Decedent the Manyland 10a, State 10b. County 10d. Inside City Limits 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No MaryLand Prince George's Director SuitLand 10e. Street and Number 10a. Citizen of Whet Country? 10f. Zlp Code with 20746 U.S.A. 4811 Bennett Avenue Funeral death 12. Was Decedent Ever in U,S.
Arroed Forcas?

1 Yes 2 No
If Yes, Giva Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexicen, Puerto Rican, atc.) Race - American Indian, Bleck, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Nevar Married 2 Married 1 ☐ Yes ZZ No Specify: BLack altimore, Maryland 21215-0020 Specify. à 3 Nidowed 4 Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Hygiene. Printer Federal Government 7 is marked other traumatic event, u 18. Mother's Name (First, Middle, Melden Sumeme) 17. Fether's Name (First, Middle, Last) Be Earl Scott Mary Sewell 20 19a. Informent's Name/Relationship (Type, Print) RusseLine J. KyLe (Daughter) Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4811 Bennett Avenue SuitLand, MaryLand 20746 nt of Health a H Item 27 is or other tra 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Page Department of Important: If any Injury or once. Fort Lincoln Cemetery 3/8/2000 Brentwood, MaryLand 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 22 ROCLINS OF ONER ACTIONE. INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** . HYPERTENSIVE ARTERIOSCIEROTIC CARPIOVASCULAR DISEASE Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner and Il-transit The law requires that the death certificete be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In deeth) Last Due to (or as a consequence of): physician ar Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of) for use es signed by the aid be deteched for Part II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PROSTATE OF CARCINOMA þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed page 2 20 No 2XXNo r this certificate h 1 ☐ Yes 1 Tyes Division of Vital Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifica stelly filled in by the funeral director, i Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 8 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28b. Tima of 5 Pending investigation Natural 1 Yes 2 No Z Accident in 24 hour the Funeral Director filled in by the 3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur MARCH 06. 2000 30. Name end eddress of person who complete! cause of death (Item 23a) (Type, Print) MARIO F. 300 HOS WRIVE

State Registrar GOLLE

MAR 0 8 2000

31. Date filed (Month, Dey, Yeer)

32 Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** Shirley Joseph 03 0635 5-2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hospital Regional Prince George's Laurel Laurel Hours Min. 8. Dete of Birth (Month, Day, April 28, 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months M 20 F 63 241-52-6359 North Carolina Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 Yas 2 □ No Directo Maryland | Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or death with 7103 Valley Park Road 20743 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elamentary/Secondary (0-12) College (1-4or 5+) Hyglene. Private 2yrs. Engineer permit. Pages 1 and 2 should be file Department of Heelth end Mental Hy Important: if Item 27 Ia marked othe any Injury or other traumatic avent, bloca. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emmanuel Shirley Cherry Gay 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louise L. Shirley/Wife 7103 Valley Park Road, Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State Harmony Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) Landover, Maryland 21. Signatura of Funeral Sarvice Licensee J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failing. List only one ceuse on each line. Approximata Intervel Between Onset end Death **Physician** Immediete Cause (Final diseasa or condition rasulting in daath) 1-2 de /Medical Sepsis Examiner Examiner rac that the death certificate be executed physician end s the burial-transi Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that Initiated events resulting in daath) Last Due to (or as/a consequence of) P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 980 0 ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown nemia signed b Division of Vital Records, þ 24b. Wera eutopsy findings evailable prior to 24a. Was an autopsy Completed Post Subdural harmatoma evacuation completion of cause of death? is certificate has director, page 2 Hy Renterion 1 Yes 2 No 1 Yas 2 KNo 25. Was casa rafarred to medical examiner? Attending Physicien: Be 26. Place of Death (Chack only one) Hospital: Othar: 4 Nursing Home 5 Residence 8 Othar (Specify) To 1 Yes 20 No 1 Impatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) Certification: 5 Panding investigation 1 Natural 2 Accidant s after de... I Director: Aftr 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hou.
The Funeral Discrete Fulled in by 4 Homicide 6 Hospital 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one) To the Within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier 3-5-00 023/81

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31. Date filed (Month, Day, Year) MAR 0 8 2000

RIG BHOJRAJ.

30. Name and addrass of person who completed ceusa of death (Item 23a) (Type, Print)

704 GORMAN AVE # T-1 LAUREL, MD 20707 M.D. . Registrar's Signature

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** March 6, Molly D. Sanford 2000 11:00 PM /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Undar 1 Year | If Undar 24 Hrs. B. Date of Birth (Month, Dey, Year) Jan. 26, 19 5. Social Security Number Birthplace (State or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Days Hours Min 97 Yrs. 147-14-3815 1903 New Jersey Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. fnsida City Limits 28a-f ahow r than "natural", or items 23s or 28s-f ahor the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Prince Georges Fort Washington 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 117 Aragona Dr. 20744 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bieck, White, etc. 11. Merital Status 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White p 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry then Elementery/Secondery (0-12) Coilega (1-4or 5+) Homemaker At Home permit. Pages 1 and 2 should be filed v Department of Heelth and Mentel Hygies Important: If Item 27 is marked other it any injury or other traumatic event, ITS 00059. 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surnama) Frank Diorio Carmela Cresi 19a. fnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Ronald J. Sanford, Sr. same as item 10 20a. Method of Disposition 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cramation 3 🛣 Removal from Stete Calvary Cemetery 3/9/2000 Paterson, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature meral Sarvice Licenses George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD alus or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, event failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting in death) /Medical Bacteremia 5 days Examiner Dua to (or as a consaquence of): 5 Days Examiner Sepsis or Attanding Physician: The law requires that the death certificate be executed buriel-trans Sequantially list conditions, if any, leading to immediate cause. Enter Undarfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Completed by Physician/Medical the Dua to (or as a consequence of) for 23b. Dfd tobacco use contributa to the causa of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 94 detached 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings 24a. Was an autopsy performed? should available prior to complation of cause of death? pege 2 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No of Vital 25. Was casa referred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ finpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Othar (Specify) Certification: To 1□ Yes 2□ No this 27. Manner of Death 28a. Dete of fnjury (Month, Dey Year) 28b. Time of 28c. fnjury at Work? 28d. Dascribe how injury occurred 5 Pending investigation Division 1 Netural s after deeth. 1 TYes 2 □ No 2 Accidant 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of fnjury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 Homleida Hospitai within 24 hours a edicai 1 Cartifying Physician: To the best of my knowledge, daath occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 0 D45365 3/7/2000 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Michael Sidarous, M.D. 11701 Livingston Rd., #171, Ft. Washington, MD 20744 31. Data filed (Month, Dey, Year) 22. Redistrar's Signeture. State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Adela Herrera Salvador March 2,2000 8:30pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Yrs 577-06-2862 Director 9 - 7 - 39Guatemala Ci Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show rait, or itama 23a or 28a-f shov Examiner must be notified as 1 Yas 2 No Director MD Prince George Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9205 New Hampshere Ave Herne 23e 20903 Funeral Guatemala 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marifal Status 72 hours after 1 Never Married 2 Married 1 Yas & No Baltimore, Maryland 21215-0020 'netural', or ty Yes 2 No Specify. Specify: p 3 ☐ Widowed 4 ☑ Divorced Hispanic Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7 Department of Heelth and Mental Hygiens. Important: if tem 27 is marked other than "n any injury or other traumatic event, trailled. Bridges. Elementery/Secondary (0-12) College (1-4or 5+) 8 + Private Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Emilio Valencia Josefina Herrera 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Pulliam (Daughter) 13029 Gersnwin Way Silver Spring, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burlal 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland National 3-6-00 Laurel, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snead Funeral Home& Cremation Service 5732 Georgia Ave N.W. Washington, DC 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate fnterval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting In deeth) Examiner Due to Physician/Medical Examiner 2 sicien and burial-transit Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lasf Box 68760, 10 vas avar Disease Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o. 1 Yes 2000 3 Probably 4 Unknown م Records. Completed by 58 24b. Were eutopsy tindings available prior to 24a. Was en autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of fnjury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division After 1 Natural 5 Pending after death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the To the To the P Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesville Rd Silver Spri 80 31. Data filed (Month, Day, Year) 32 Regisfrar's Signature State MAR 0 8 2000 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Month :30Am Year Robe E 0) 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death many's County Charlotte Hall ST Charlotte Ha11 reterans Home If Under 1 Year | If Under 24 Hrs. | Montha Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10 M 2□ F Yrs. 515-18-6016 December 21, 1924 Kansas Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Prince George's Maryland Glenarden Woods 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 7900 Cawker Avenue 20706 USA 12. Wes Decedent Ever in U,S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 Yea 2 No Specify: If Yes, Give Year or Dates: Specify: Black 3 Widowed 4 Divorced 1946 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Industry Elementery/Secondary (0-12) College (1-4or 5+) Information Specialist Dept. of State 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leonard Sowell Cora Venable 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. tnforment's Neme/Reletionship (Type, Print) Ethel Sowell/wife 7900 Cawker Avenue Glenarden Woods, MD 20706 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetery3-9-00 Cheltenham, Maryland 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signeture of Funeral Service Licensee MOOR-10MC 4308 Suitland Road Suitland, MD 20746 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death reval Renal Cell Carcinoma Immediate Cause (Finei disease or condition resulting in death) arvohi Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t, 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Offiknown tension 24b. Were eutopsy findings svailable prior to 24a. Was en autopsy parformed? completion of ceuse of death? 2 0 No 1 Yes 2 No 25. Was case referred to medicel examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Naturat 5 Pending 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

288-1

23a or

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21215-0020

Baltimore, Maryland

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Pages 1 and 2 should nant of Health and Man

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Lepartment of Health a Important: If New 27 is any injury or

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Funeral

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Completed

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physician and s the burial-transit Physician/Medical 2 signed b à Completed page 2 Be

this Attending death. Hospital or Attend 24 hours after death Funeral Director: To the Hospital of within 24 hours at To the Funeral Completely filled

P.O. Records, Vital of Division

9:30Am

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2000

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narch

29b. Signature and this of certifier State

Registrar

31. Date filed (Month, Day, Year)

Certification: To

edicai

2 Accident

4 Homicide

3 ☐ Suicide

29e. Certifier

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Janelle

MAR 0 7 2000

Investigation

6 Could not be determined

mp Bel

32 Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Charlotto Hall Rd Charlotto

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

TANK OF 1800 SAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Certificat	e of	Death		F	Reg. No.	JU	09/99
	Physician /Medical	1. Decedent's Name (First, Middle, the Charles Thomas S							2. Date of Dea Month March 4		Year	3. Time of Deeth 4:00 AM
	Examiner	As Franklik Mana III and institution also stand and asset and						Anne Arundel				
	Funeral Director	218-24-0979	Sex 7. A	ge (In yrs. last birth 68 Y	nday) If Under Months	1 Year Days	If Under Hours		8. Date of Birth (Month, Day Mar . I 6	, 1931	9. Birtho Mary	place (State or Foreign Arry) Land
d 21215-0020 filed within 72 hours after death with the Mandand	ter death with the Manyland tem 23a or 23a-f show the man be notified at Tuneral Director	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Maryland Prince George's Bowie								1	0d. Inside City Limits Yes 2 □ No	
	23a or 2 unt be ny	10e. Street and Number 2403 Kenly Place		10f. Zip Code 20715					10g. Citizen of What Country? United States			
000	burs after death v rail, or forms 23 Francis munt by Funeral	11. Meritel Stetus 1 □ Never Merried 2 ☒ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces' XX Yes 2 If Yes, Give Yeer or Detes:	No1951-	13. Wes Dece ff Yes, spe 1 \(\subseteq Yes				cify Yes or No- Rican, etc.)		ca - Americ ck, White, y: Whi	etc.
15-0	ed within 72 hours ygiene. or than "natural", t, me wed all E.	15. Decedent's (Specify only highest g	Education rade completed)	1	Decedent's Usu Give kind of wo	rk done	during mos	t of workin	ng	16b. Kind of B	usiness/in	dustry
212	Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Comple	Elementery/Secondery (0-12)	College (1-4or	Weapons Specialist			US Air Fo		Force	orce		
Maryland 21215-0020	should be filed and Mental Hyg s marked other umatic event, To Be C	17. Father's Neme (First, Middle, Las Walter Alvin Sto					18. Mothe	er's Name	(First, Middle, Fanning		ne)	
, Man	2 sh and is m	19a. Informant's Neme/Reletionship Marilyn Stommel/			Maiting Address 03 Ken1						, State, Zip	Code)
Baltlmore,	permit. Pages 1 and Department of Health Important: if frem 27 any Injury or other to once.	20e. Method of Disposition 1 Burlel 2 Oremetion 3 4 Donetion 5 Other (Spec	□Removel from Stete	cemetery	Disposition (Nai cremetory or o Cremato	ther pla	ce)	3,	Date /4/2000	20c. Location Waldon		
Balt	Departi Departi Importa any Inj any Inj	21. Signature of Funerel Service Lic	plus)		22. Name ar	d Addre			eral Ho d Bowie	me MD Inc	0715	
		23a. Pent. Enter the disease, from shock, or heart failure. List on	mplications that cause y one cause on each I	d the deeth. Do no							1	Approximate Intervel Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	Myoca	ardial	I	nfa	vct	ion			1	5 Days
L	alper st	resulting in deeping	Anox	Due to (or as a co	onsequence of):	Ph	300	ath	1		1	5 Days
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P.O.	at the d I by the etached	Part il. Other significant conditions	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown			
of Vital Records,	The law requires th cate has been signed, page 2 should be d								24a. Was e perfor	an autopsy med?	av	era autopsy findings allable prior to impletion of cause death?
E B	sician: The law certificate has b firector, page 2 s o Be Compl								1 🗆 Y	es 200 No	10	Yes 2□No
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	D 0 0	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ury 28b. Ti	me of	8c. Injui	4 D M	-	ne 5 🗆 Resid			ý)
lon	Attending or death. octor: After by the fune iffication	1 Natural 5 Pending investigeti		ly Year) Inj	jury M		Yes 2	No				
Ź	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not 4 Homicide determine	jury - At home, fam c. (Specify)					8t. Location (Street and Number or Rurel Route Number, City or Town, State)				
	Hospi 24 hour Funer Holy fil	29e. Cartifier (Check only one) Cortifying F	hyaician: To the best miner: On the basis o end menner st	f examination and	death occurred for investigation	at the ti	me, date an opinion, dea	nd place, a oth occurre	and due to the ded at the time, o	cause(s) and m date and pleca,	anner as s and due to	stated. the cause(s)
	7 111	29b. Signeture and title of certifier	- My	tall r	29	. Licens	+(2-	-1b		MAR.	4, Z	Day, Year)
	15) (Va	30. Name and eddress of person who	all, M.D	. 90	ype, Print)	ty	ate 1	Rd_	Ann	apolis	M	9
	State Registrar	31. Dete filed (Month, Day, Year) MAR 0 7 2001		rer's Signeture	Spar	in	,			1		

Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00000

				Cei	rtificate of	Death	R	eg. No.	09000		
		1. Decedent's Neme (First, Middle, La.					2. Date of Deal Month	h	3. Time of Death		
	Physician /Medical	Dorothy Giles Sm		March 4	2000	2:50 P.M.					
	Examiner	4a Facility Name (If not institution, giv	4b. City, Town, or Location of Deeth 4c. County of Death								
		Larkin-Chase Nur			H f l - d - d W - s -	Bowie			George's		
ı	Funeral Director	220 30 1304	7. Age (In yrs. 70	last birthday) Yrs.	Months Days	Hours Mi		1929	9. Birthplece (State or Foreign Country) Virginia		
	D E.	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits		
	with the Marytav a or 28s-f show be notified at Director			anham	10f. Zip Code			1 ☑ Yes 2 ☐			
douth the 23	ath with a 23a or a sauthen							Inited S	tates		
	ar, or he Examine by Fur	11. Meritel Stetus 1 Never Merried 2XXMerried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	☐ Yes 2 No Yes, Give 1 ☐ Yes 2 🕅			(Specify Yes or No- erto Rican, etc.)	Bleck,	- American Indien, White, etc. White		
5	od within 72 ho tygene. we than "nature it, the Medical. Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced (Give	dent's Usuel Occu kind of work done DO NOT use retire	pation during most of w	rorking	16b. Kind of Busi			
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an	d be the the the the the the the the the th	Thomas C. Giles					S. Daltor				
J.	marke marke	19a, Informent's Neme/Reletionship (Type, Print)	19b. Meilir	ng Address (Street		Rural Route Number		tate, Zip Code)		
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ore,	of Heart	20e. Method of Disposition	20b. I	Plece of Dispo	sition (Neme of natory or other pla	ce) Mano	h 7, 2000	20c. Location - C	ity or Town, Stete		
Ĕ	Page ment: If my or	1 Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specify	Induitoral Itotil Stata		In Cemet	erv	11 / 5 2000	Brentwe	ood, Maryland		
Baltimore,	Departit Departit Importa any info	21. Signeture of Funeral Service Licen		22 R	Neme end Addresobert E.	Evans	uneral Ho				
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io	Attending or death. octor: After by the fune fileation	1 Accident 5 Pending investigation		injury		Yes 2□No					
Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could not be 4 Homicide determined	28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			281. Location (Si City or Town	281. Location (Street end Number or Rurel Route Number, City or Town, State)				
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	9	SQ. Neme and address of person who o	D 72000	1 23a) (Spe.	aneh a	ve (Unton	MO			
	State Registrar	31. Dete filed (Month, Day, Year) MAR 0 7 2000	32 Registrar's Signe	B.	Spale	,					

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Data of Death 3. Tima of Death Month 03 Mabell Stevens **Physician** 0530 04 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Cheverly Georges Hospital H Under 24 Hrs. 8. Date of Birth (Month, Pay Year)
May 29, 1922 If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 25 F North Carolina 238-40-3208 77 Director **Usual Residence of Decedent** the Maryland 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at 1 N Yas 2 No Maryland | Prince George's Director Hyattsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or hams 23s or 7206 East Forest Road 20785 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exemples page. Black, Whita, etc. 1 Never Married 2 Married 1 Yas 2 No Specify: Baitimore, Maryland 21215-0020 Specify: þ Black. 3 ☐ Widowed 4 M Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker 10th Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) William West Lucy Autry 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Freeman/Niece 3960 Turkey Highway, Clinton, North Carolina 28328 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 03/07 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 4 Donation 5 Other (Specify) 2000 Brentwood, Maryland 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 Perc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Physician Cerebral Hemorrhage /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burief-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) . Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, 2 24b. Wara autopsy findings available prior to completion of cause of death? should should Completed 24a. Was an autopsy performed? 1□ Yas 2⊟No 1 ☐ Yas 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: After t 5 Pending investigation in 24 hours effer death.
The Funeral Director: After the funeral Director: After the funeral by 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only one) within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Al Aborton D. D. P11804 Ma 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) SAL SY LVESTER, D. O. Mary IANd Hospital cheverly Drive 32 Registrar's Signatura 31. Data filed (Month, Day, Year) MAR 0 7 2000

DHMH 16 Rev 6/95

Registrar

Date to the state of the same

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 9802

P.	1. Decedent's Name (First, Middle, Las		30.11	ficate of	_ +	2. Data of De Month	Reg. No. ath Day	Year	3. Time of Death
Physician /Medical	Jacquerine F. Stewart						17 8	000	505 Am
Examiner	4a Facility Name (If not institution, give Washington Adv		ital		4b. City, Town, or Takoma P	Location of Death	4c. County of Death Montgomery		
Funeral Director	3,3 30 1,1,1	7. Age (In		f Under 1 Year fonths Deys		8. Date of Bird Month, Da	Y2, 1933	9. Birthpla Counti BOS	ce (Stete or Foreign
pu k	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City L								
Many Heho	Maryland Prince	George's	La	urel					1 No 2 No
filed within 72 hours after death with the Maryland Hydione. Hydione. Inter then "natural", or items 23s or 28s-f show ont, the Maryland Enement on notified at the Maryland Enement on notified at a Completed by Funeral Director.	10e. Street and Number 8022 Sandy Spring	g Road	4.3	10f. Zip Code	20707		10g. Citizen of W	hat Count	•
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Mental Hygicarka other atic event, to Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Na						Maiden Sumamo	9)	
E	19a. Informant's Name/Relationship (T				t and Number or A			State, Zip (Code)
other tr	Julia A. Scott 20a. Method of Disposition		1314 0b. Place of Disposition		Lane, B	Date MD		City or Toy	m State
= E	1 ☐ Burial 2 ☐ Cremelion 3 ☐ F	Removal from State	cemetery, cremate	ory or other pla					
ortant: Injury	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	n		Cremat		3/14/200			
Important: if any injury or once.	21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., D.C. 20019								
	23a. Pert1 Enter the disease, or comp shock, or heart failure. List only of	ications that caused the ne cause on each line.							Approximate Intervel Between Onset and Death
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B. B.	25. Was case referred to medical examiner?	Jacobski		100		eath (Check only o	one)		
T Sign	1 Yes 2 2 No 27. Menner of Death 1 Noturel 5 Pending 2 Accident Investigation	28a. Date of Injury	28a. Date of Injury (Month, Day Year) 28b. Time of Injury W			Other: 4 Nursing Home 5 Residence 6 Other (Specify) tnjury at Work? 1 Yes 2 No)
al Director: After tied in by the funeral Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Funer tely fill		sician: To the best of my ner: On the basis of examined manner stated.							
within 2 To the compla	29b. Signature and title of certifier	· · · · · · · · · · · · · · · · · · ·	1	29c. Licen	se number		29d. Date signed	(Month, D	Pay, Year)
	Marsun O.	9	m.	D23743 March 7, 2000					000
LT LT	30. Neme and address of person who co Martin D. W		(Item 23a) (Type, Prir Greenway		r., Green	belt, MI	20770		
State Registrar	31. Date filed (Month, Day, Year) MAR 1 0 2000	32. Registrar's S	Signature	,					

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 8, WAYNE CHARLES SCHMALER MARCH 2000 5:45P,M. /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner NATIONAL INSTITUTE OF HEALTH Rethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Deys Hours 1 XM 2 □ F Yrs. 49 Sept.29,1950 138-44-6439 **Director** New Jersey Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. toslde City Limits "natural", or items 23a or 28a-f show ideal Examiner must be notified at M☐ Yes 2☐ No Directo Washington New York Cossayuna 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? P O Box 242 12823 U.S.A. death v Funeral 14. Reca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Merital Status Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiena. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify: Specify.White by 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry end Mental Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) 12th Construction Worker Private Industry 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Edward Schmaler Alice True Flynn 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 89 permit. Pages 1 end 2: Department of Heelth el Important: If Item 27 is any Injury or other trau once. Diane M. Schmaler - Wife P O Box 242 Cossayuna New York 20b. Placa of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 3-10-00 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name end Address of Facility
Marshall's Funeral Home, Inc. hlia 4217 9th Street N.W. Washington DC 23e. 1.1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical RESPIRATORY FAILURE Examiner Due to (or es a consequence ot) Examiner CANCER CELL physicien end s the burial-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequenca of): 98 ettending p 23b. Did tobacco use contribute to the cause of death? deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t d be detech 1 Yes 2 No 3 Probably 4 Ninknown þ The lew requires 24b. Were autopsy findings available prior to bleen si 24a. Wes an autopsy performed? Completed completion of cause of death? page 2 s 1□ Yes 200No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28a. Dete of tnjury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. tnjury et Work? Certification: After 1 Netural 5 ☐ Pending 1 Yes 2 No death. Investigation Director: A 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, State) in 24 hour. Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) To the I Within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 00 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M. BATTIWALLA MD.

Registrar

31. Date filed (Month, Dey, Year) MAR I 0 2000



STATE OF THE PARTY
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yee **Physician** 1100 AM Leopoldo P. Sison 09, 2000 4c. County of Death MARCH /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth Examiner WASHINGTON PR 24 Hrs. 8. Date of Birth (Month, Day, Year) July 23,1947 PRINCE GEORGES LOUGHRAN 8706 ROAD If Under 24 Hrs. Birthplace (State or Foreign Country) If Linder 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 52 Days 1⊠M 2□ F Months 562-86-5536 Philippine Is. Director Usual Residence of Deceden 10d. Inside City Limits 10a State 10c. City. Town or Location 10b. County ms 23a or 28a-f show must be notified at 1 X Yes 2 □ No Maryland Prince George's Ft. Washington Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20744 Funeral 8706 Loughran Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces?

1 XYes 2 NoRetired
If Yes, Give 14. Race - American Indian, Black, White, etc. **Berns** 11. Meritel Stetus then "natural", or item the Medical Examiner. 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2€No Specify: Specify: Asian/Filipino þ 3 Widowed 4 Divorced 1998 Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Retired US Navv Military permit. Pages 1 and 2 should be flat.
Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumetic events. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Desiderio Sison. Sr. Emilia Palaganas 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Sison/Wife Same as item 10 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Arlington National Cemetery3/15/2000 Arlington, VA. Funeral Service Lige George P. Kalas Funeral Home, P.A. 21. Signatu ales 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 11. Enter the disease, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one, ladse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final a. HYPERTENSIVE ARTERIOS CLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner Bnd -tren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) certificate be exec -leinid Records, P.O. Box 68760. Physician/Medical the Due to (or as a consequence of) 80 950 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown á 1 ☐ Yes 2 ☐ No bengis be de p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen page 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Yes 2□ No 1 Inpalient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of Certification: Injury at Work? Affer 1 Natural 2 Accident 5 Pending Injury efter deeth. 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp ithin 24 ho To the Fune 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 0 ofed cause of death (IIgm 23a) (Type, Print) MAPLO GOLVE 31. Date filed (Month, Day, Year)
MAR 1 0 2000 32. Registrar's Signature State Registra

DHMH 16 Ray 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#10e&19b PER F.H. G781 3-24-2000 JAB 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 1, 2000 **Physician** Carolyn Smith Clark 01:15 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year 5. Social Security Number Birtholace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 2 Months Days Hours Min. Director 214-52-4619 Nov 9, 1948 West Virginia 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD 1 Yes 25 No P.G. Temple Hills Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 Cedell Place 4702 CEDELL PLACE 20748 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 Yes 20 No If Yes, Give Year or Dates: Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Never Employed N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Dayton Smith Ellen F. Bare Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) $\frac{4702}{702}$ Cedell Place, Temple Hills, Maryland 20748 Ellen F. Smith/ Mother 20b. Place of Disposition (Name of cemetery, cremetory or other place) March 6, p2000 | 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cunningham Memorial Park St. Albans, W. Virginia 21. Signature of Funeral Service 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 M01095 t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Intervat Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a co 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 D tinknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1Dres 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10

Hospital: 1 Dinpatient 1 Yes 2 No

5 Pending

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes

2 No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examination The basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s)

Naficy Mohammond, MD 3001 Hospital Drive, Cheverly, MD

29b. Signature and sile of tage

Investigation

6 Could not be determined

29c. License number D1418Z 29d. Date signed (Month, Day, Year)

March 3, 2000

Registrar

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and Mental Hygiene.

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permit. Page Department of Important: If any injury or

physician and the burial-tran

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Certification:

Medical

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efter death.

24 hours e

To the within 2

P.O. Box 68760

Division of Vital Records,

Hospital or Attending Physician:

Baltimore, Maryland 21215-0020

31. Date filed (Month, Dev. Yeer,

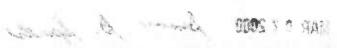
MAR 0 7 2000

32. Registrar's Signature O. Sparks

cause of death (Item 23e) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95



the transfer of the same of th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09806 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year 1920 RALPH H. THOMPSON MARCH 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 72 221-12-7899 10-23-1927 DELAWARE Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d Inside City Limits 1 ☐ Yes 2 No DELAWARE SUSSEX HARBESON 10f Zin Code 10g. Citizen of What Country? 10e Street and Number 19951 2 WATERSIDE LANE. PINE WATER FARM U.S.A. 12. Was Decedent Ever in U.S. Armed Forces2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes ZONo 1 Never Married 2 N Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) RETAIL STORES Elementary/Secondary (0-12) College (1-4or 5+) DISTRICT SUPERVISOR 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) GEORGE THOMPSON VIRGINIA WILLIAMS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAZEL M. THOMPSON/ WIFE 2 WATERSIDE LN., PINEWATER FARM, HARBESON, DE 19951 20b. Place of Disposition (Name of cemetery, crematory or other place) MELSON'S CAPE HENLOPEN CREMATORY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Spther (Specify) 3-8-00 FRANKFORD, DELAWARE 4 Donation 21. Signature of Funeral Service Virginia 22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 day Acute Myscardial Infareto disease or condition resulting in death) Due to (or as e consequence of): 0 Yn Coronary artis Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a gonsequence Athan sclensis Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown rescepe 24b. Were autopsy findings aveilable prior to completion of cause of death? post Kadlation Prostale 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Director

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Pages 1 and 2 should be fit ment of Health and Mental H ant; If them 27 is marked oth lury or other traumatic aven

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Physician/Medical eigned by page 2 should be Completed cartificata I or Attending Physician: aftar death. Director: Aftar this cartifica Be Certification: To

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Mospital 24 hours a Funeral D plataly within 2 To the

DHMH 16 Rev 6/95

Division

State Registrar

MAR 1

5 Pending

investigation

6 Could not be determined

25. Was cese referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

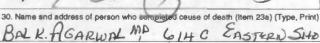
3 Suicide

29a. Certifier

4 Homleide

(Check only one)

29b. Signature and title of cartille



rewal on

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

EASTERN SHORE DR

28c. Injury at Work?

1 Yes 2 No

ORIGINAL

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

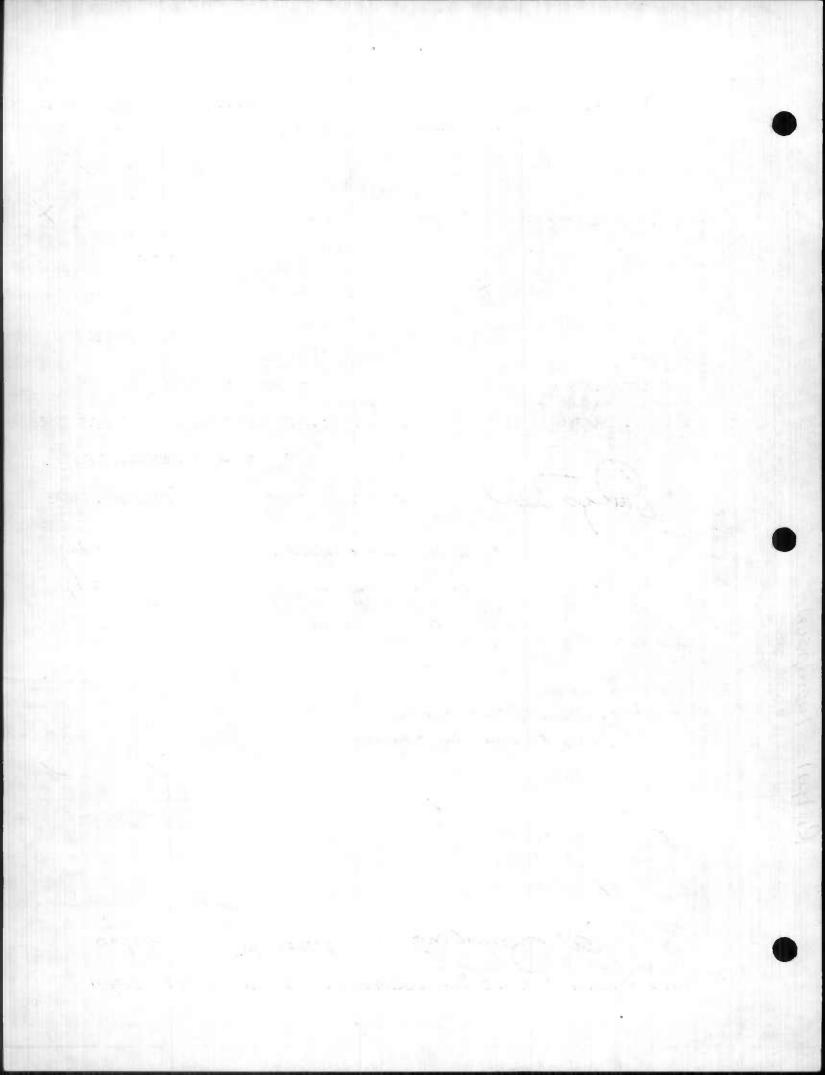
1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 17181 MD

DALISAURY, IND. 21804

BALK. AGARWAL MA 31. Date filed (Month, Dey, Year) 32. Registrar's Signature



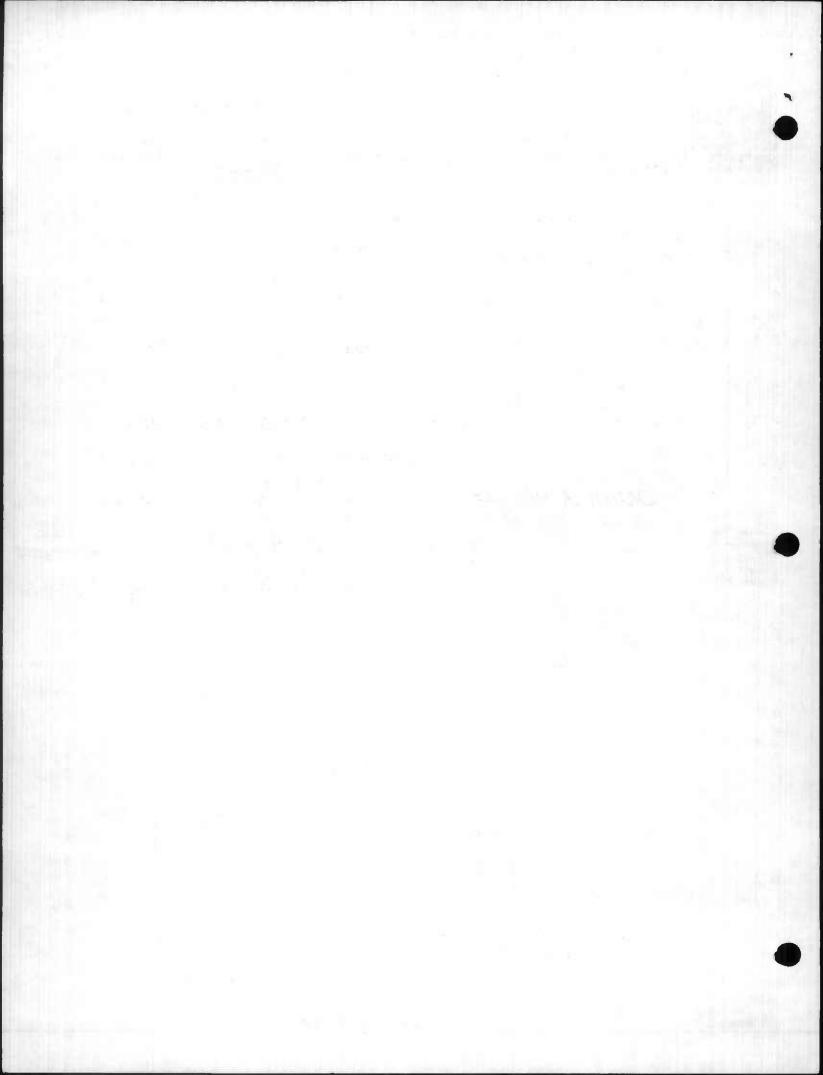
Amended Items #2&23a, Per Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death MonHarchoa, 2000 1. Decedent's Name (First, Middle, Last) **Physician** Carrie Anna Thomas 3:00PM /Medical 4a. Facility Name (If not institution, give street and number) 26452 Royal Oak Street 4b. City. Town, or Location of Death 4c. County of Death Examiner TALBOT Easton If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 XF 219-34-3065 77 Yrs. Director Md Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Talbot Easton Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21601 Herns 23a 26452 Royal Oak Street USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours effer in ent of Health and Mental Hygiene. Int: If them 27 is marked other than "natural", or its 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) domestic College (1-4or 5+) housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Depertment of Health ar fmportant: If item 27 is any injury or other trauonce. Celeste Rone (granddaughter) c/o 26452 Royal Oak St Easton, Md 21601 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial Park Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/6/2000 Sykesville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between 10 t and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and P.O. Box 68760, physician Physician/Medical the Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? signed by the 1 | Yee 2 Probably 4 Unknown Records, þ 24b. Were eutopsy findings aveilable prior to completion of ceuse of death? should Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, I å 25. Was cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how Injury occurred Certification: 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of ceptifie 29c. License number 29d. Date signed (Month, Day, Year) on who completed cause of deeth (Item 23a) (Type, Print) hilling D 2540 Centrus // R& Centrus He WX 21617 Russell A Schilling DU 31. Date filed (Month, Day, Year)

Registrar

State

MAR 0 8 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day MARCH 5, 2000 Jane T. Taylor 11:58 P.M. 4e Facility Name (II not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Leonardtown St. Mary's Hospital St. Mary's If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 03/12/26 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplaca (State or Foreign Days Months Hours 1 M XXF Maryland 577-38-8729 Vre 73 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10a. Stete 10d. Inside City Limits St. Mary's Leonardtown No 2 No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22680 Cedar Lane Court #1409 USA 20650 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: Specify:Black 3∑ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Mack Mary A. Jones 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Mary Mack / Aunt 20615 Waterloof Circle Coltons Point, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Number 2 ☐ Cremetion 3 ☐ Removel from State Sacred Heart Cemetery 3/13/2000 Bushwood, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Furnital Service Licensee 22. Neme and Address of Facility Dunn & Sons 5635 Eads St. NE DC 20019 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth fmmediete Ceuse (Final diseese or condition resulting in deeth) Due to (or es a consequence of): A5 055, ble PIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or as e consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 146-Tes MecciTus 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Severe Coronary Disease 1 □ Yes 20 No 1 Yes 25. Wes case referred to medical 26. Placa of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 | Inpatient 2 | ER/Outpatient 27. Manper of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Neturat 5 Pending investigation 1 Yes 2 No

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Examiner Physician/Medical Be Completed Certification: To

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Funeral

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rai', or items 23s or 28s-f show Examiner must be notified at

natural', or

permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If farm 27 is marked other than "n any injury or other traumatic avant, to a Health phose.

Physician

/Medical Examiner

72 hours after

Maryland 21215-0020

Baitimore,

JANE

TAYLOR,

Hospital or Attending Physician: illed in by To the Hospital of within 24 hours a To the Funeral D completely filled

edical State

31. Date filed (Month, Day, Year)
MAR 1 0 2000

29b. Signature and the of certifier

3 Suicide

29e. Certifier

4 Homicide

314285

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29d. Dete signed (Month, Day, Year) 3-6-00

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. WILLIAM D. BOYD II

6 Could not be determined

LEONARDTOWN, MD. (1977) 20650

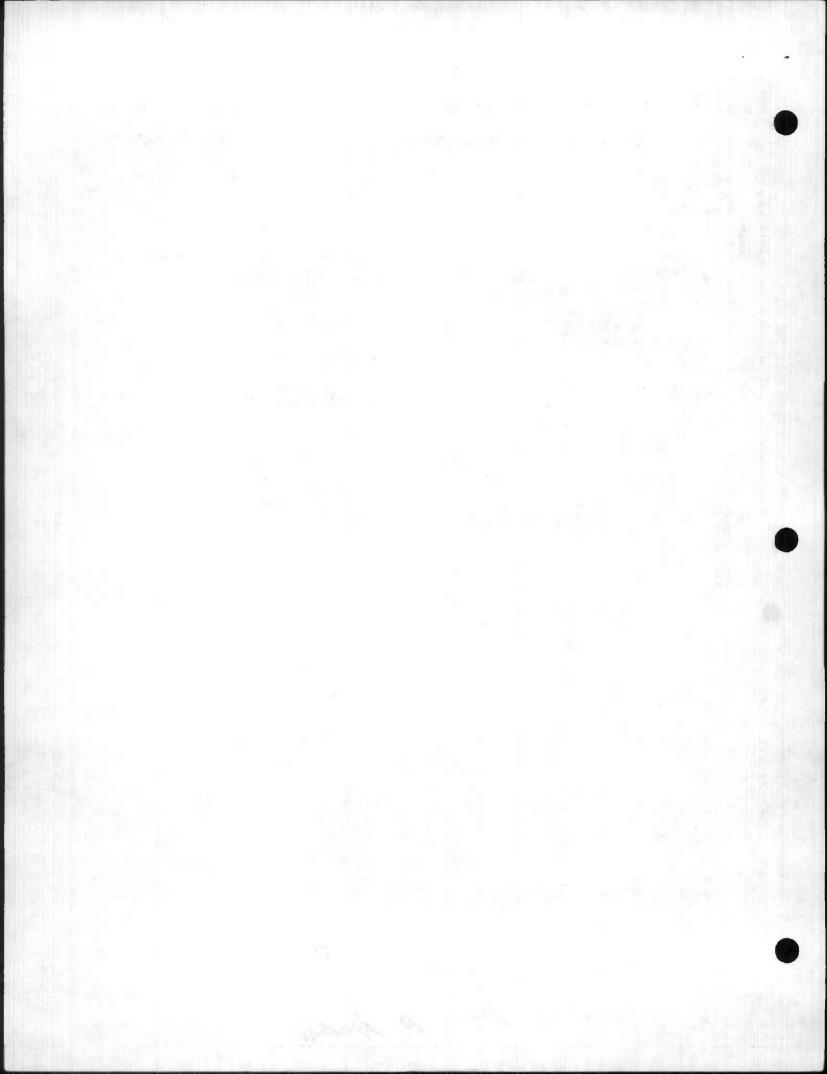
29c. License number

3. Registrer's Signeture oorke

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

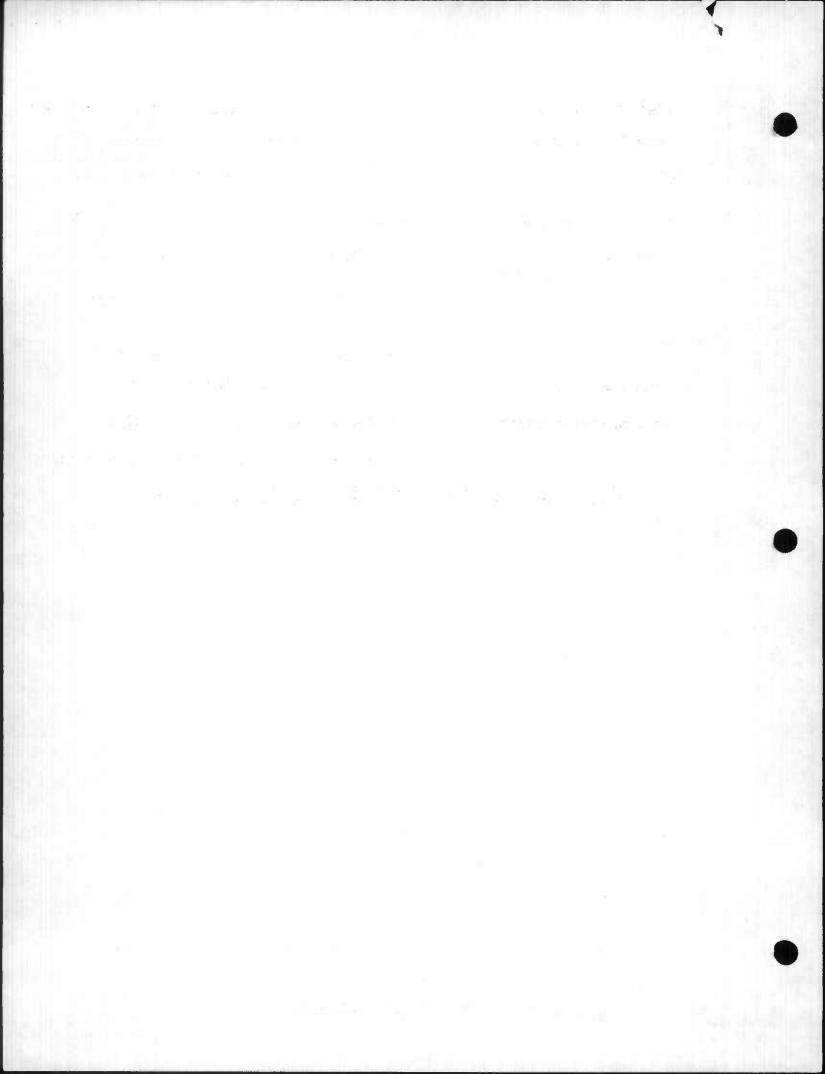
Registrar

State of Maryland / Department of Health and Mental Hygiene Amended #29c/ 03/07/00 WCHD/ HLC Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Day Month **Physician** Doris Irene Dutton Truitt monch /Medical 3 3000 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 1 Year ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Steta or Foreign Country) **Funeral** Days Months Hours 1 M 2 KF Director 221-10-1560 July 4, 1916 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Funeral Director Sussex Delmar 23s or 28s-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 402 Jewel Street 19940 U.S.A. Herre 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. the Medical Examine 1 ☐ Yes 2 🛣 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 T Married 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Food Supervisor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be George M. Dutton Nettie Lowe Dutton and a 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) If Nem 27 is 402 Jewel Street George B. Truitt/Husband Delmar, DE 19940 altimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Department In 4 ☐ Donation 5 ☐ Othar (Specify) St. Stephens Cemetery 3-5-2000 Delmar, Delaware 21. Signetura of Funeral Service Licensee 22. Nama and Addrass of Facility Short Funeral Home william 23a. Part 1. Enter the disease, of complications that daysed the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Delmar, DE Approximata Interval Between Onset and Death **Physician** Heart /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical the the Due to (or as a consequence of) 8 signed by the attending I be detached for use as Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Yes 2 No 1 Yes 2 No this certificate Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menney of Deeth 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 1 AMetural 5 Pending after death. 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of fnjury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide ŏ To the Hospital c within 24 hours at To the Funeral D. 29a. Cartifier edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29c. License number D0054127 29b. Signatura and file of confile 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (from 23a) (Type, Print) DAVIS 13150 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 7 2000 Registrar



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State of Maryland	/ Department of Health a	nd Mental Hygiene	U	1	

hysic		1. Decedent's Neme (First, Middle, L	ast)			ate of		2. Dete of D	Reg. No.		3. Time of Death
/Medi		Edwin E. Van Ta	assell					Month March	9, 200	Yeer)0	6:30 A.M
/weui Exami		4e. Facility Neme (If not institution, g	ive street and number)		-		4b. City, Town,	or Location of Dee			
		Waterview Healt					Salis			omico	
ineral rector		5. Social Security Number 6. 087-18-6861 Usuel Residence of Decedent	Sex 7. Age (In) 1 ★ M 2 □ F 76	yrs. last birthe Yr	Month	ler 1 Year s Deys		Irs. 8. Dete of B (Month, D) 8-17-	irth ay, <i>Year)</i> 1923	9. Birthr	oleca (Stete or Foreigntry) N.Y.
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00 PG	Director	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of	What Cou	ntry?
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Mental Hygiene. arked other than "natural", or flems 23s or 23s-f show atic event, the Medical Examiner must be notified at		11. Maritel Status 1 🕅 Never Merried 2 🗆 Merried 3 🗆 Widowed 4 🗆 Divorced	12. Was Decadent Ever II Armed Forces? 1 Yes, Give Yeer or Detes:	n U,S.			spenic Origin? en, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)		14. Rece - American Indien, Bleck, White, etc. Specify: White	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death Day Month Yaar **Physician** TULL 2000 0255 BILLY T.J. MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not Institution, giva street and number) Examiner ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpleca (State or Foreign Country) 6. Sax 8. Dete of Birth (Month, Dey, Year) **Funeral** Min 1 MM 2 F Months Deys Hours Yrs. 65 Director MARYLAND 217-36-0285 JAN. 19, 1935 Usuel Residenca of Decedent the Marylend 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits 1 Yes 2X No Directo MARYLAND WORCESTER WHALEYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours efter death with r than "naturel", or items 23s or the Medical Examiner must be 12047 BLUEBERRY ROAD 21872 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Detes: 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grede completed) Elamantary/Secondary (0-12) College (1-4or 5+) AGRICULTURE FARMER 8 18. Mother's Name (First, Middle, Melden Sumeme) 17. Fether's Name (First, Middle, Last) Be Peges 1 and 2 should be fament of Health and Mental Int: If Item 27 Is marked of **EDNA** MOORE TULL RODDIE 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) 12047 BLUEBERRY ROAD, WHALEYVILLE, MD 21872 SHIRLEY F. TULL/WIFE item 27 Baltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 X Buriel 2 Cremetion 3 Removel from State permit. Pege Department of important: If eny injury or once. = 0 3/6/00 WHALEYVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) DALE CEMETERY 22. Name end Address of Fecility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediete Ceusa (Finai Coronary diseese or condition resulting in deeth) artery disease Examiner Dua to (or as a consequenca of Examiner physician and s the buriel-transit requires that the death certificate be axecuted Sequantially list conditions, if eny, leading to immediate cause. Enlar Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): attending p 98 signed by the a d be datached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 1 Yes 2 No 3 Probably 4 Unknown P 24b. Ware autopsy findings aveilable prior to 24a. Was an autopsy Completed performed' completion of causa of death? s certificata has t director, paga 2 s 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: after death. Director: After this certifica director, 25. Wes case referred to medical examiner? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 28a. Date of injury (Month, Dey Year) funeral 28c. Injury at Work? 27. Menper of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident ector: / 6 Could not be datarmined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida 24 hours after
 Funeral Dire
letaly filled in b 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated. edical To the Hosp within 24 hor To the Fune completaly fi 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the tima, data and placa, and due to the ceuse(s) and menner stated. (Check only one) 29d. Data signad (Month, Dav. Year) 29c. Licansa number 29b. Signeture end title of certifi D 41721 03/03/00 30. Nama and addrass of person who compiated causa of death (itam 23a) (Type, Print) 15

E. SIDRE

DA.

-SALISBURY

21804

400

STEPHAN PAVIOS

31. Deta filed (Month, Day, Year) MAR 0 7 2000

DHMH 16 Rav 6/95

State Registrar

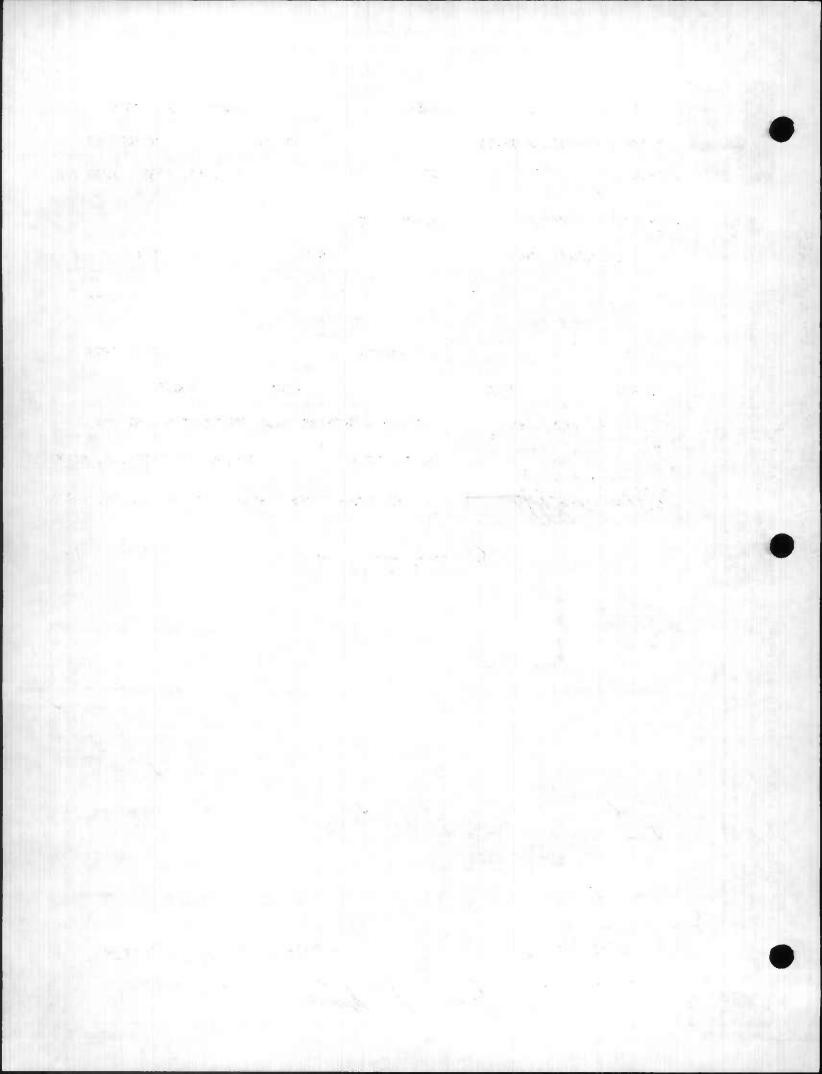
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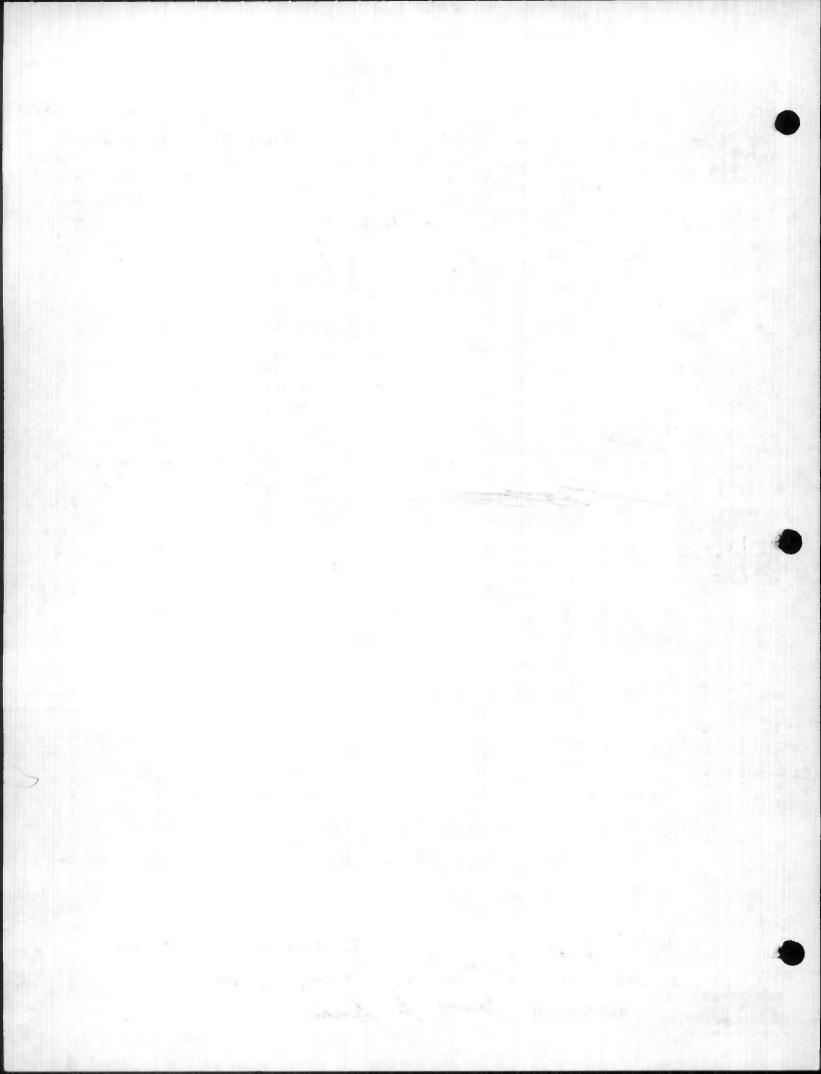
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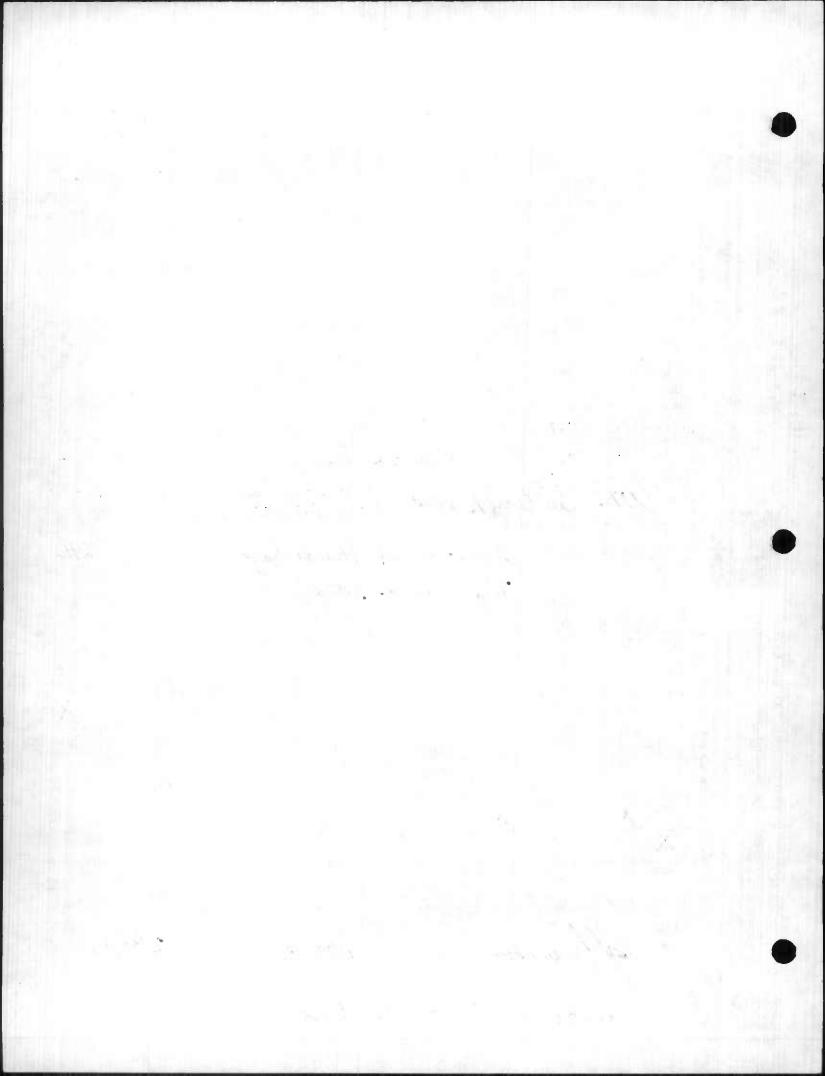
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 2 2

	1. Decedent's Nama (First, Middla, Last		rtificate of Death	2. Data of Daath	J. No.	3. Time of Death
Physician	FURIA	Tucker		Month March	Day Year 2000	1: 50 0 m
Medical/ Examiner		street and number)	4b. City, Town,	or Location of Death	4c. County of Death	1.30/1/1
	Deer's He	rad Center	Salis	bury	W: com	1100
neral ector	5. Social Sacurity Number 6. Sa 2/3-66-/863 10 Usual Rasidance of Dacadant	7. Aga (In yrs. last birthday) 7 Yrs.	If Undar 1 Yaar III Undar 24 H Months Days Hours M	frs. 8. Data of Birth in. (Month, Day, y		laca (Stata or Foraign http:) LYLANC
Mo to	10a. Stata 10b. County	10c. City, Town or Lo	cation		1	Od. Insida City Limits
28a-1 show notified at	md Wit	omico SAL	isburg			1 465 2 No
Dire	10e. Street and Number	1 10 101 01	10f. Zip Coda	100	. Citizan of What Cour	itry?
era e	351 DERR'S HAND	7	21801		USA	
by Funeral Director		1 Yas 2 No	Was Dacedant of Hispanic Origin? f Yas, specify Cuban, Maxican, Pu 1 ☐ Yas 2 ☐ No Specify:	(Specify Yas or No- arto Rican, atc.)	14. Race - Amaric Black, Whita, Symplify:	an Indian, atc.
led t	15. Decedant's Edu		dant's Usual Occupation	16	b. Kind of Businass/Inc	dustry
nt, the Modical	(Specify only highast grad	a complated) (Giva Collaga (1-4or 5+)	dant's Usual Occupation kind of work dona during most of v DO NOT usa ratired)	vorking	S. Nips of Basillass in	Justiny
event, Be C	17. Fathar's Nama (First, Middla, Last)	21 1	1 000 16	lama (First, Middla, Ma	idan Sumama)	
To Be Co	Michael +	OBERTSON	MAI	y Ellis	5	
sumatic	19a. Informant's Name Ralationship (Ty	/	ng Addrass (Street and Number or	1	City on Town, Stata, Zip	Coda)
other tr	William		WHIN ST +	T	FRUITAND 1	nd.
	20a. Mathod of Disposition	amoval from Stata	sition (Nama of natory or other place)	Data 20	c. Location - City or To	wn, Stata
Important: If any injury or once.	4 Donation 5 Other (Specify)	SLBANAC	ers Mam DK	1/1/201 5	Alisbury	Md.
any i	21. Signature of Funarai Sarvica License	22	. Nama and Addrass of Facility	SENNIR S	mich of	+
	23a Part 1 Foter the disease or compli	cations that caused the death. Do not antia cause on each line.	17 W. ISAbel	a 5%	SALISBU	
ician dical niner	Immadiata Causa (Final disaasa or condition rasulting in daath)	Lung ma Dua to (or as a conseq Oneumon) a	ss, probably	maligne		Approximate Interval Batween Donset and Death Operation of September 98
the burial-transit	Sequentially list conditions,	Dua to (or as a consaq	uenca of);			Jux-1-
	Causa (Disaasa or injury	Dulmonary	edema		į	3 days
Medical	that initiated evants resulting in daath) Last	Dua to (or as a donsequent	A		i	1-
0 2		Renal	Pailure		i	12days
I for use	Part II Other standings of any distance					
id be datached f	Arten es denotic	tributing to death but not resulting in the ur			2 No 3 Prob	1/
2 shou	Hypertensm			24a. Was an a performe	d? ava	ira autopsy findings illabla prior to inplation of cause death?
irector, page 2 sirector, page 2 s				1 🗆 Yas	2 DNO 10	Yas 2□ No
ector, Be	25. Was casa rafarred to medical axaminar?			aath (Check only ona)		
- E	1 Yas 2 No	ospital: 1 Inpatiant 2 ER/Outpatien		Homa 5 Rasidano)
To the Funeral Director: After to completely filled in by the funeral Medical Certification:	1 (2 Natural 5 Panding 2 Accident invastigation	28a. Data of Injury (Month, Day Year) 28b. Tima of tnjury	28c. Injury at Work? M 1 ☐ Yas 2 ☐ No	28d. Dascribe how	Injury occurred	
completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicida 6 Could not be 4 Homicida datarmined	28a. Piace of Injury - At homa, farm, stre building, atc. (Specify)		281. Location (Stras City or Town, S	at and Number or Rura Stata)	Routa Number,
pletely fille	29a. Cartiflar (Check only one)	ician: To the best of my knowledge, death ar: On the basis of axamination and/or inv and manner stated.	occurred at the fime, date and pie astigation, in my opinion, death oc	ca, and dua to tha caus curred at tha tima, data	sa(s) and mannar as st and piace, and dua to	ated. tha cause(s)
W Comp	29b. Signatura and fitla of cartiflar		29c. Licansa numbar	29d.	Data signed (Month, I	Day, Yaar)
	1 Life	verp	D 1600;	3 .	3/7/00	10
	30. Nama and addrass of Parson who con	nplated causa of death (Itam 23a) (Type, I	Print)		1/	
	PO BOX 2018,	Salisbury, M	0 21802-2	0/8		
State	31. Data filed (Month, Day, Year)	32. Ragistrar's Signatura				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 4b. City, Town, or Location of Death 54c. Courty of Death Alice Betty Trice 1600 /Medical 4a Facility Nama (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M XX F Days Hours Yrs. Director 213-22-8082 October 20,1928 Maryland Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City. Town or Location t0d. Inside City Limits 28a-f show 1 Yes 2 □ No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Name 23a 700 Hammond Street 21804 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes 2 No Specify: Specify: White by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Carrier Newspaper marked other 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame and Mental Benjamin Bozman Mildred Department of Health and Important: If Itam 27 is m any injury or other traum bace. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Disharoon/Daughter 700 Hammond Street, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 2/25/2000 Salisbury, Maryland 21. Signature of Funeral Service Lioghs 22. Nama and Address of Facility Holloway Funeral Home, Professional Association CF3 501 Snow Hill Road, Salisbury, MD 21804 of the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, 23a. Pert1. Enter the disease, or complications the shock, or heart failura. List only ona cause Intarvat Batween Onset and Deeth **Physician** Immediata Causa (Final diseasa or condition resulting in death) 24hr /Medical Hemorshage Examiner Examiner the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or as a consequence of): USB P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably Unknown Records, by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed completion of cause of death? 1 🗆 Yas 2 No 1 Yas 2 No of Vital Be 25. Wes casa refarred to medical axaminer? 26. Place of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1/Neturat 5 Pending investigation Division Attanding 1 Yes 2 No 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hou. 4 ☐ Homicide Hospital ZCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Continue to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the Tot 29b. Signature and title of partition 29c. License number 29d. Data signed (Month, Day, Year) 100 on, who completed causa of death (Item 23a). (Type, Print) Mi Hord St 32. Registyr's Signatura State FFR 2 8 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

09814.

3. Time of Death

3:35 AM

10d. tnside City Limits 1 Yes 2 No

Birthplace (State or Foreign Country)

MARYLAND

2. Date of Death

Month Dey Year February 15, 2000

20c. Location - City or Town, State

14. Rece - American Indian, Bleck, White, etc.

WHITE

/Medical	Thomas	Frankl	in Twic	gg						Februa	ry 15,	20:00	3:
xaminer	4a Facility Neme (if not institution,	give street end num	iber)				4b. City, To	wn, or Li	ocation of Deat	h 4c. Coi	inty of Deal	th
	Salisbur	ry Cenite	r: Genesi	is Elde	rCare			Salis	bury	, MD	Wic	comico)
neral ector	5. Social Security N 218-14-25		5. Sex 1 M 2 □ F	7. Age (In yrs.) 7.4	last birthday Yrs.	Months Months	Days		Min.	8. Date of Bir (Month, Di OCT • 26	rth ay, Year)		thplace (Sountry) RYLAN
	Usuel Residence o	of Decedent								pozv ze	,, 1, 1, 1,	11111	(111111
	10a. Stete	10b. County		10c. City	10c. City, Town or Location								10d. tns
be notified Director	MARYLAND	WICOM	ICO		SALISBURY								1 🗆
5	10e. Street and Nu	mber				10f. Zi	p Code				10g. Citizen	of What Co	ountry?
	1521 MAGN	NOLIA DR					2	1804			U.	S.A.	
2 hours after death vetures? or theme 23s cal Examiner must sed by Funeral	11. Maritel Stetus 1 Never Men 3 Widowed		12. Was Deced Armed Ford 1 1 Yes If Yes, Give Year or De	ces? 2 □ No WW	No			Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, Yes 200 No Specify:			es or No- etc.) 14. Rec Ble Specify		orican Indi e, etc. VHITE
eted	(Spe	15. Decedent's city only highest		16a. Decedent's Usual Occupation (Give kind of work done during most of wo					ing	16b. Kind o	of Business	Industry	
completed	Elementery/Second 12	ondery (0-12)	College (1-	4or 5+)	ELECTRICAL CONTRACTO				ror		OWN	BUSI	NESS
Be	17. Father's Neme	(First, Middle, La	ist)		18. Mother's					ther's Name (First, Middle, Maiden Sumeme)			
ToB	THOMAS I	PURNELL	TWIGG		GRAC					ACE CHATHAM			
10.2	19e. Informent's N	eme/Reletionshi	p (Type, Print)		19b. Meil	ing Addres	s (Stree	et and Numb	er or Run	al Route Numb	er, City or To	wn, Stete.	Zip Code)
	NORMA R.	TWIGG -	WIFE		1521	MAGN	NOLI	A DR.	SAI	SALISBURY, MD 21			
	20e. Method of Dis	•	I □Removel from S		20b. Place of Disposition (Name of cemetery, crematory or other place)					Dete	20c. Locati	on - City or	Town, Sta
Š		5 ☐ Other (Spe			COMICC	MEMO	ORIA	L PARE	2	/21/00	SALIS	BURY,	MD
any injudical	21. Signeture of F	uneral Service Li	TA PA	Pomm C	550			ess of Facili		, INC.	705 E. SALI	MAIN	
Physician	23a. Part1. Enter t shock, or hee	the disease, or contral	omplications that canly one cause on ee	used the death och line.	n. Do not en	iter the mo	de of dy	ing, such as	cardiac	or respiretory a	irrest,		Appro Intervi Onset

1. Decedent's Name (First, Middle, Last)

		,	
11/1	FUNERAL HOME, INC.	705 E. MAIN	
BOUNDS	FUNERAL HOME, INC.	SALISBURY	, MD 21804
s that caused the death. Do not enter the mose on each line.	ode of dying, such as cardiac or respiretor	y arrest,	Approximate Intervel Between Onset and Death
lower contines	Sestind Re	el	mally
Due-to for es a consequence o	ŋ:		41-
Due to (or as a consequence of		178	
Due to (or as a consequence of	any accept		ges

/Medical **Examiner**

Examiner burial-transit physician sthe burial Physician/Medical signed by the attending p Completed by Be Medical Certification: To

or Attanding Physician: The law requires that the death certificate be executed

certificate

24 hours after death Puneral Director: A filled in by

within 2 To the

Division of Vital Records, P.O. Box 68760,

art II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t.									

	23b. Did tobed	co use co	ntributa to the c	nuse of death?
	1 🗆 Yaa	2□ No	3 Probably	4 Unknown
L				

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yas 2 ☐ No

25. Was case referred to medical	26. Place of Death (Check only one)								
axaminer? 1 Yes 2 No	Hospitel: 1 tnpatient 2 ER/Outpatient 3 [A Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)							
27. Menner of Death 1 ☐Natural 5 ☐ Panding 2 ☐ Accident Investige	on M	8c. Injury at Work? 1 Yes 2 No							
3 Suicide 6 Could no determin		office 28f. Location (Street and Number or Rural Route Number, City or Town, State)							

	(Check only one)	
_		-

Immediate Cause (Final disease or condition resulting In deeth)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) D 29349

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

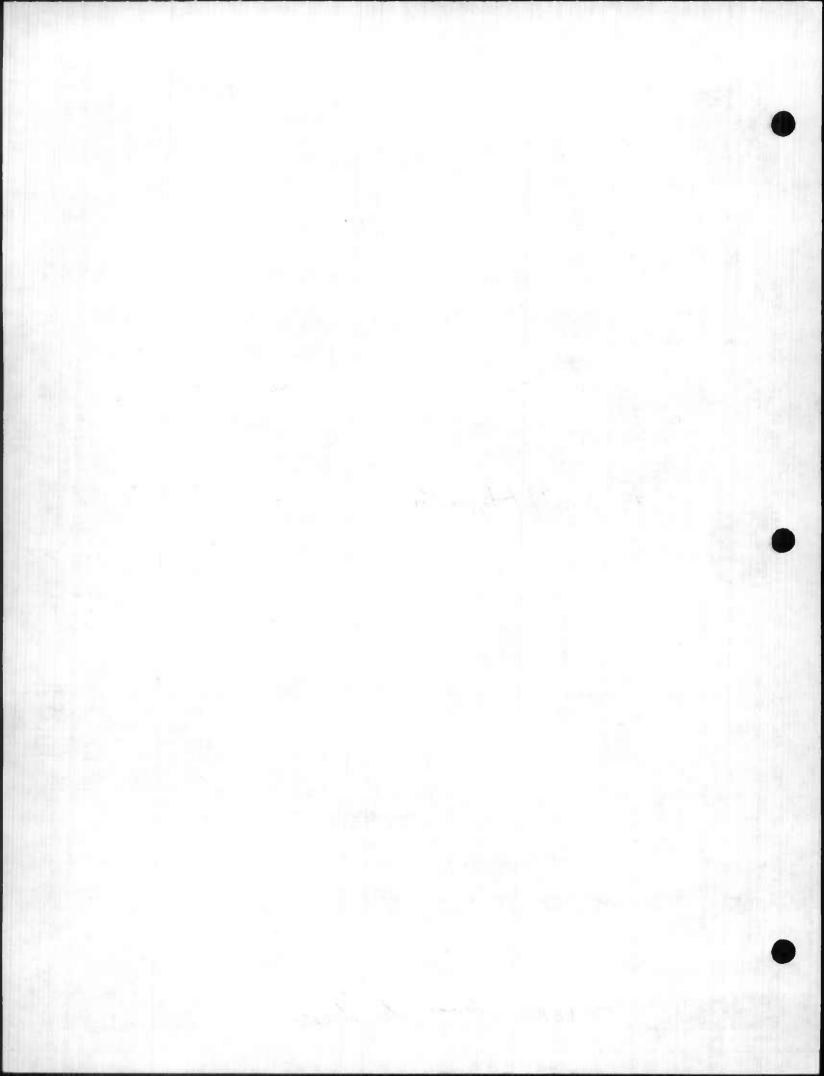
William H. Robins, M.D. 1104 Healthway Dr., Salisbury, MD 21804

State Registrar

31. Date filed (Month, Dey, Year) FEB 1 8 2000

32. Registrar's Signeture

parks



State of Maryland / Department of Health and Mental Hygiene 00 098 | 5

EASTON MD 21601

			17.00			Cer	tificate c	of Death		Reg. No.		
	Physician /Medical	1	. Decedent's Name (First, Middle, L PAUL ROBERT		ER, S	R.			2. Dete of De Month March	Day	Year 2000	3. Time of Death 5:45 PM
	Examiner		a Facility Neme (If not institution, g	ve street end numb	er)			4b. City, Town,	or Location of Deat	h 4c. Count	y of Death	
	Funeral Director	5	561-54-1275		he Pi Age (In yrs. 86	nes last birthdey) Yrs.	If Under 1 Ye Months De				9. Birthple Countr NEW Y	C Ice (State or Foreig ORK
	pu .		Usuel Residence of Decedent 10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation				100	d. Inside City Limits
	darylar f ahow	- 1	VA FAIRFA	x		ALEXANI						YSYes 2□No
	or 28e-f at the market	1	Oe. Street and Number			TDDMMIL	10f. Zip Cod	θ.		10g. Citizen of	What Countr	****
	th with the sale of the sale o		5529 EDGEMONT	DRIVE				310		US		
5-0020	020 urs after dee al', or flerms	2	1. Meritel Stefus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decede Armed Force 1 [2] Yes 2 If Yes, Give Yeer or Dete	s? □No		Ves Decedent of Yes, specify C		(Specify Yes or No erto Rican, etc.)	14. Ra Ble Speci	ce - America ack, White, et ty: WHI	lc.
21215-0	within in the second	15	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 11 15. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) MILITARY OFFICER							16b. Kind of E		CORPS
Maryland	Mental H Mental H arked out arts even		7. Father's Neme (First, Middle, Las VAN ELROY TYLER						Neme (First, Middle MARIE SM		me)	
-			19a. tnformant's Neme/Reletionship MARIE U [†] REN / D	(Type, Print) AUGHTER		127 5	. HARR	ISON ST.,	EASTON,			kode)
Baltimore,	Pages 1 an nent of Heel mt: If Item 2 iry or other	2	0e. Method of Disposition 1 Burial 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Spec		10	emetery, crem	sition (Neme of netory or other (NATIO)	NAL CEM.	3-27-00	20c. Location		
Balti	pemit. Pag Department Important: b any Injury o page.	1	21. Significant At Funerel Service Lice	Lunen	A/CI	TO FE	ELLOWS,		EIN & NEW			OME, P.A.
	Physician /Medical	1	23a. Part1. Enter the disease, or cor shock, or heart feilure. List only mmediate Cause (Finel disease or condition	nplications that cause one cause on each	1.	h. Do not ente	or the mode of	failu	liec or respiretory e	rrest,		Approximete Interval Between Onset and Daeth
L	Examiner	Medical Examiner	esulting In death)		che co	or es a consequ	uenca of):				1	vecks
(68760,	ng physicia as the bur		Sequentially list conditions, I any, leeding to immediate ause. Enter Underlying Lause (Disease or injury het initiated events esulting in death) Last	c. pr	Due to (0	r es a consequence of the conseq	den	enfo			7	Harr
O. Box	for L	F	art II. Other significant conditions	d	but not res	ulting in the un	derlying cause	given in Pert I.	23b. Did	tobacco use c	ontribute to t	the cause of death
9									10	Yes 2□ No	3 Probe	ably 42 Unknow
Records,	aw requires is been sign 2 should be						-12-		24a. Was	an autopsy ormed?	avati	re autopsy findings flable prior to apletion of cause eath?
	The late he pege								10	Yes 20 No	10	Yes 2□ No
Vitai	ysicien: The sectificate director, per	2	5. Wes case referred to medical axeminer?						Deeth (Check only	one)		
of	High T		1 Yes 2 No	Hospitet: 1 - Inpo		ER/Outpatient	3LI DOA		g Home 5 Resi			
Division	After fune	2	7. Menner of Death 1 ☑ Neturet 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not		njury Day Year)	28b. Time of Injury		njury et Nork? Yes 2 No		how injury occu		
Divi	ital or Attenders all Director: ied in by the Certifical		3 Suicide 6 Could not 4 Homicide determined	200. PIBOR OF	Injury - At he etc. (Specif	ome, ferm, stre	eet, fectory, offi	ca	28f. Location (City or To	Street and Num wn, State)	nber or Rural	Houte Number,
	Hospi 24 hou Funer Funer ately fill			nysician: To the be miner: On the basis end menner	of examine							
	To the To the comple	2	9b. Signature and title of certilia	P)	MI		29c. Lic	ense number		29d. Date sign	ed (Month, D	ay, Year)

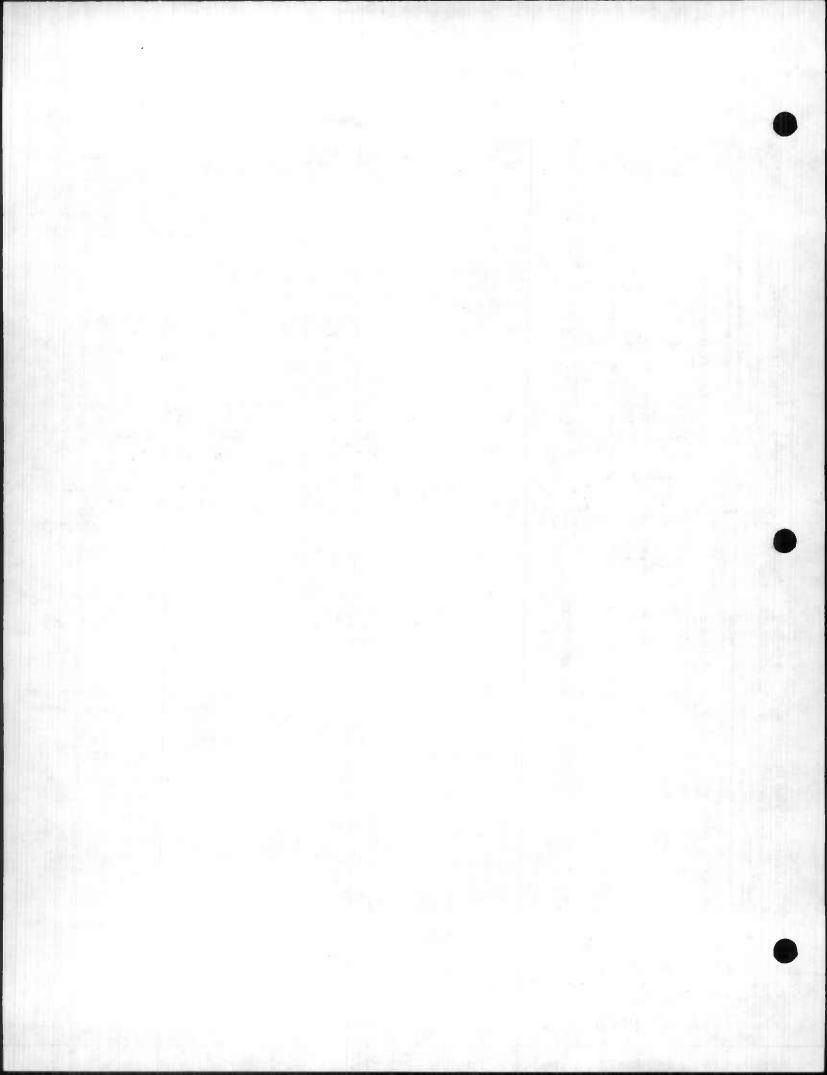
State Registrar

MAR 0 8 2000

31. Date filed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (IJem 23a) (Type, Print), ROBLET SANCHES, MD 508 INLEWILD

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 00 09816

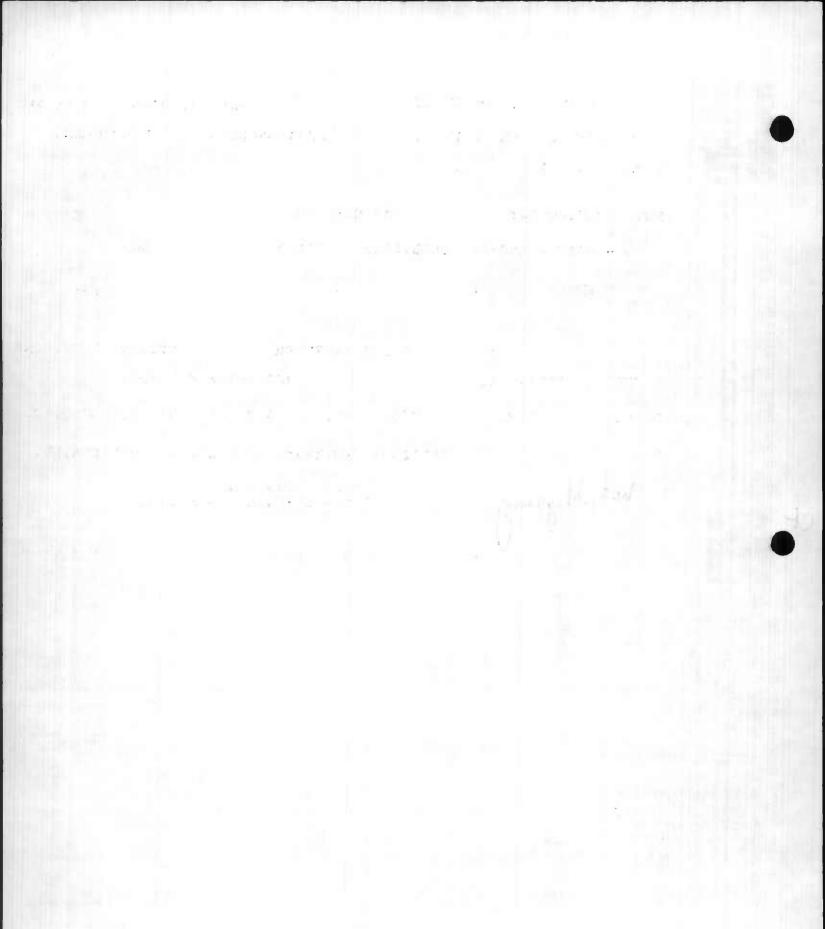
				Certifica	te of	Death		Re	eg. No.		0 3 0 1 0		
	1. Decedent's Name (First, Middla, I	ast)		81.			2	. Date of Deat Month		Year	3. Time of Deeth		
sician edical	Roy Ar	nos I	emple				M		Day 1, 2000		2215		
niner	4a Fscility Name (If not Institution, g	iva street and number)	~			4b. City, To		tion of Death	4c. County		2210		
	Union Hospital					Elk	ton		Ced	cil			
ral			e (In yrs. last birth		r 1 Yaar	If Under	24 Hrs. 8	Date of Birth		9. Birthol	aca (Stata or Fore		
or	179-01-3200	1M 2□F	84 Y	rs. Months	Days	Hours	Min.	(Month, Day,		Count	sylvania		
	Usual Residence of Decedent							101 23	1010	I CIIII	Sylvania		
	10e. Stata 10b. County		10c. City, Town							10	d. Inside City Limi		
tor	Maryland Cec:	11	Elk	Mills							1X Yas 2□N		
Directo	10e. Street and Number			10f. Zi	p Code			1	0g. Citizen of \	What Count	iry?		
	631 Elk Mills Re	oad		2	1920				United	State	es		
Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dece	dent of	Hispanic Orio	gin? (Specif	v Yas or No-	14. Rac	e - America	an Indisn,		
Ē	1 Never Married 20XMarried	Armed Forces?					, Puarto Ric	can, atc.)	Blac	ck, Whita, a			
	3 □ Widowed 4 □ Divorced	If Yes, Giva Year or Dates:	1939-42	1 ☐ Yas	2 🔯 No	Specify:			Specify	. Whi	te		
	15. Decedent's	100000000000000000000000000000000000000	16a I	Decedent's Usi	al Occu	nation			16b. Kind of B	usinass/Ind	ustry		
Completed	(Specify only highest g			Giva kind of w	ork done	during most	of working				ctrical		
ľ	Elementary/Secondary (0-12)	College (1-4or :	5+)	Owner/									
	17. Father's Name (First, Middla, La	2	1	OWIICI/	oper	_	re Name /		Motor I	_			
9	Harvey Temple Florence Cole									10)			
2													
	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State,										Code)		
	Marie M. Temple	/Wife				Elk Mi			nd 2192				
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Domousi from State	20b. Place of i	Disposition (Na , crematory or		ice)	i	Data :	20c. Location -	City or To	wn, Stata		
	4 Donation 5 Other (Spec		Sharp	s Cemet	ery		3/	15/00	Fair H	ill,	Maryland		
	21. Signature of Funaral Service Lic	ensee				ass of Facility							
		0 11 4						als, P			01001		
_	Donald S- Luker 103 W. Stockton St., Elkton, Maryland 21921												
	23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
	tmmediete Cause (Fine)												
	disease or condition rasulting in death)	e. COP	D							1	20 yrs		
	Due to (or as a consequence of):												
		b. Aor	tic Sten	osis						1	2 mo.		
	Sequentially list conditions,		Dua to (or as a co	onsequence of	:								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Mit	ral Requ	rgitati	on					t	2 mo.		
2	that initiated events resulting in death) Last	C	Due to (or as a co							t	L mo.		
Medical	rooding in odding cost									1			
		d											
5	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	causa g	ven in Part I.		23b. Did to	bacco use co	ntribute to	the cause of deat		
rigerolar				H				±X Y	es 2 No	3 Prob	ebly 4 Unknown		
2								24a. Was a		24b. We	re autopsy finding		
Completed	-1							perform	ned?	COF	illable prior to npletion of cause death?		
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								1 🗆 Ye	s 20 No	1 1 1	Yas 2□ No		
9	25. Was case refarred to medical examinar?	Hospital:			10		of Death (Check only on	a)				
-	1 Yas 2 No	1 Inpatie			UA		- 1		ence 6 Oth		')		
:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Data of Inju (Month, Da	ry Year) 28b. Ti	me of jury	28c. Inju	ry at ork?	28	d. Describe ho	ow injury occur	red			
cer micanon:	2 ☐ Accident investigati			М	1	Yes 2 🗆	No						
	3 Suicide 6 Could not detarmine	28e. Place of Inj	ury - At home, fan	m, street, fecto	ry, office		28	I. Location (St City or Town	reet and Numb n. Stata)	per or Rura	Routa Number,		
			(၁၉၁۵),										
		hysician: To the best											
anna anna	(Check only 2 Medical Exp	miner: On the basis of and menner st		or invastigation	n, in my	opinion, deal	in occurred	at the time, d	ate end place,	sna aue to	ma cause(s)		
	29b. Signature and title of certifier	11		29	c. Licen	se number		2	9d. Data signe	d (Month, L	Day, Year)		
1	1 Jan ////	lu			D44	716			March	13. 2	000		
	m News		least the second	Name Date:									
	30. Name first address of person who												
	// Jose Ma, M		. High S	treet,	Elkt	on, M	D 219	921					
te ar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatura	book	1								
		/ Hard	6.	114116									

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Month Yaar **Physician** 7, ARTHUR E. TROST III 2000 7:35 AM MAR. /Medical 4b. City, Town, or Location of Daeth 4a Facility Nama (If not institution, giva streat and number) 4c. County of Death Examiner MONTGOMERY 756- OUINCE ORCHARD BLVD. GAITHERSBURG Hours Min. 8. Data of Birth (Month, Day, Year) if Under 1 Year Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) 5. Social Sacurity Number **Funeral** Months Days 1 M 2 □ F 69 Yrs. 287-26-4566 APR.29,1930 Director OHIO Usual Rasidance of Decadant the Manylend 10a. Stete 10b. County 10c. City, Town or Location 10d. insida City Limits r than "naturel", or items 23a or 28a-f show the Medical Examples must be notified at GAITHERSBURG 1 Yas 2 □ No MD. MONTGOMERY Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Coda death with 20878 USA 756- OUINCE ORCHARD BLVD.#101 Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S Armed Forces? 11. Marital Status Pages 1 end 2 should be filled within 72 hours after nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "naturel", or ite ☐ Yas 2 XNo Yas, Giva 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b, Kind of Businass/industry Elemantery/Secondary (0-12) College (1-4or 5+) NATIONAL LUTH. HOME CHIEF ENGINEER 7 is marked othe traumatic event, 18. Mothar's Nama (First, Middla, Maiden Surname) 17. Fathar's Nema (First, Middla, Last) Be JOSEPHINE HARDESTY II ARTHUR E. TROST 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 756-QUINCE ORCHARD BLVD., GAITHERSBURG, MD. CINDY L. TROST- WIFE 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramovel from State permit. Page Department of Important: If any injury or page. 3/10/2000- ROCKVILLE, MD. PARKLAWN CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensaa 22. Name and Addrass of Facility HYSONG CO., INC. 1300 - N ST., NW, WASH., DC causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, each line. Approximata Interval Between Onsat and Death Physician /Medical Immediate Cause (Final S/2 years lymphoma mantle cell disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) for use es signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy peeu performed' page 2 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificata Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stely filled in by the funeral director, g 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant Othar: 4 ☐ Nursing Homa 5 🏋 Residence 6 ☐ Othar (Specify) 2 1 ☐ Yas 2 No 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 5 Panding invastigation 1X Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homloida 124 hours 6 • Funeral I To the Hospi within 24 hou To the Funer completely fil 29a. Certiflar TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and mannar stetad. 29d. Data signed (Month, Day, Year) 29b. Signeture and titla of certifiar 29c. License number D43083 MAR.9,2000 turna 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) DR. GEORGE SOTOS- 9707 MEDICAL CENTER DR., ROCKVILLE, MD. 31. Data filed (Month, Day, Year) 32. Registrar's Signature MAR 0 9 2000 Spale

Registrar



State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent'e Nama (First, Middle, Last) 2. Deta of Deeth 3. Tima of Death Month **Physician** March 3, Nannie Mae Toliver 2000 16:43 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 10 M 20 F 228-26-0183 91 May 22, Director Virginia Uaual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examinar must be notined at NOTYes 2 No Directo Washington, D.C. District of Columbia 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3333 Wisconsin Avenue N.W. USA 20016 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck. Whita, atc. hours after 1 Never Merried 2 Merried 1 Yes 2 No Baitimore, Marviand 21215-0020 1 Yes 2 No Specify: Specify: Black P 3-DWidowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Social Worker D.C. Government 17. Father's Nama (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe eny Injury or other treumatic event abids. 18. Mother's Neme (First, Middle, Meiden Sumame) 8 2 Joe Clark Ella Payne 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCINE DAVIS/Daughter 14054 Madrigal Drive Woodbridge, Virginia 22193 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 3/10/2000 BRENTWOOD, MARYLAND 22. Name and Address of Facility FORT LINCOLN FUNERAL HOME of Europral Service Ligansee MIDIS De Wusto 3401 BLADENSBURG RD. BRENTWOOD, MARYLAND 20722 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEPS1S DAYS Examiner Due to (or as a consequence of): Examiner attending physician and if for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detact 1 Yes 2 No 3 Probably 4 Unknown UPPER GASTROINTESTIMAL BLEED by 24b. Ware autopsy lindings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? DEMENTIA 2/2 No 1 Yes 2 No Division of Vital 8 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1□ Yes 2□No Medical Certification: To JI Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide hours a Funeral diagram: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil 29e. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) P. Televar MD. MARCH 6 2000 36552 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville Mp 20852 TALWAR 50 W. Edmonston #401 Dr. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 9 2000

DHMH 16 Rev 6/95

Registrar

3-00 10 LIVER NATURE

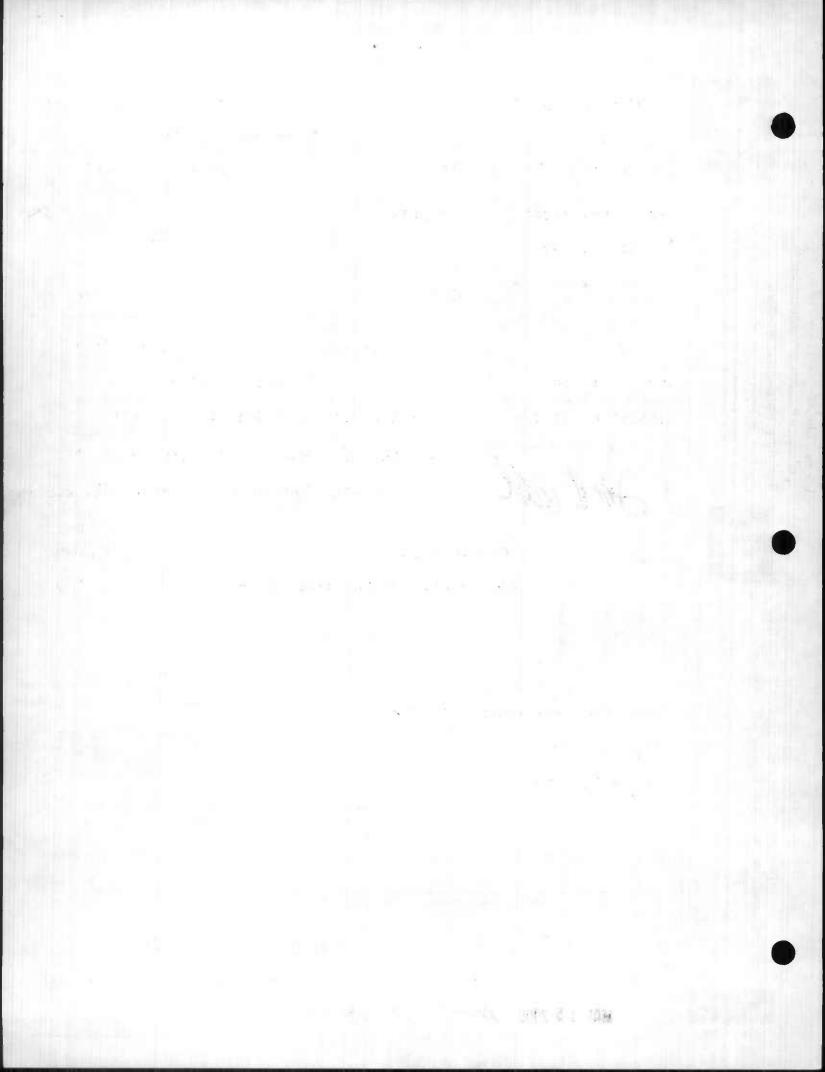
000S # 0 9AN

State of Maryland / Department of Health and Mental Hygiene 0000

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		1. Decedent's Neme	(First, Middle	Last)		40			2. Dete of I	Deeth	Voor	3. Time of Death	
Physi /Med		Lawrence	e Tinke	r					March	n 3	2000	12:13AM	
Exam		4a Facility Name (II	not Institution	give street and num	nber)				, or Location of De	ath 4c. County	of Death		
		Holy (Cross F	ospital	13011				r Spring		ntgom	nery	
Funera Directo		5. Social Security No. 579-54-0		6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 57	last birthday) Yrs.	If Under 1 Y Months De		Min. (Month, I	Birth Day, Year) 1942	9. Birthpl Count Was	lace (State or Foreign	
2 .		Usual Residence of			10.00		u.						
Maryla et shor filed at	ector	Maryland	10b. County	ntgomery	10c. Cit	y, Town or Loc Si	lver S	pring			10	od. Inside City Limits 1 Yes 2 □ No	
ar Seath with the Maryland Nerns 23s or 28s-1 show the mast be notified at	ä	10e. Street and Num 2015 E		t Highway			101. Zip Co	2091	0	10g. Citizen of What Country? United States			
bours of brank, or all Example	by Funeral	11. Meritel Stetus 1 Never Marrie 3 Widowed	U.S.	12. Was Dece Armed For 1 Tes If Yes, Giv Yeer or De	ces? 2 [XNo e			of Hispanic Origin Cuban, Mexican, F No Specify:	n? (Specify Yes or I Puerto Rican, etc.)	14. Rec Bla Specifi	ce - America ck, White, e Afr Y: Ame	an Indian, elcan erican	
5-0 72 ho	Completed	/Snan	15. Decedent	s Education		16a. Decede	ent's Usuel Or	ocupation one during most o	f undina	16b. Kind of B	usiness/Ind	iustry	
21 man 21	oldu	Elementery/Secon		grade completed) Cotlege (1-	4or 5+)	life. D	O NOT use re	tired)	Working				
21 wage	Con			1			La	borer			rnmer	it	
D HITTON	e B	17. Father's Name (18. Mother's	Neme (First, Midd		-,		
yla New Men	2		ond S.							. Hawkins			
Baitimore, Mar semit. Pages 1 and 2 ats Department of Health and Important. If them 27 is m my Injury or other treum miss.		19e. Informant's Na Sandra		ip (Type, Print) - Niece					or Rural Route Num			Code)	
		20a. Method of Disp 1 Burial 2 C 4 Donetion	Cremation	3 □Removel from Secify)	Stete	Place of Disposementery, cremo	atory or other	place)	3/10/20	20c. Location		on, D.C.	
Balt permit. Departs imports any inju		21. Signature of Fur	neral Service L	Course	111			ddress of Fecility		ewart Funeral Home N.E. Wash., D.C. 20019			
		23a. Party Enter th	e disease, or	complications that cannot one cause on ea	used the deat						2.0.	Approximate	
Physicia:	, MI	shook pr hear	tallure. List	nly one cause on ea	ich line.						i	Interval Between Onset and Death	
/Medica		Immediate Cause (I	Finat	D		C					1	6 Months	
Examine	r	resulting in death)		a. <u>PT</u>		Cancer					1	0 FIGHTIS	
	Je				200 10 (0	. as a solioods	0.100 0.7.						
acuted and I-transi	xami	Sequentially list conditions, If any, leading to immediate											
68760, tificate be asseuted g physician and as the bunal-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events Due to (or as a consequence of):											
Box 68 sath certifica attending ph for use as th		resulting in death) L	ast	d							1	1634	
death cer death cer attendir	Physician/M	Part II. Other signifi	cant condition	e contribution to de	ath but not ree	ulting in the un	darbing cause	a given in Pert I	23h Di	d tobacco use co	ntribute to	the cause of death?	
O. the	hys			a continuating to de	atir but not res	uning in the uni	Jerryling Causi	given in Feit i.		Yes 2 No		pably 4 Unknown	
P, P	y P	A	nemia						'		22.10		
of Vital Records, P.O. Box Physician: The law requires that the death cer this certificate has been signed by the attendin ral director, page 2 should be detached for use	Completed by									as an autopsy rformed?	ava	ere autopsy findings allable prior to mpletion of cause death?	
Vital Rec	duc								4.0	Yes 2 No		Yes 2 No	
in: T	Ö	25. Was case referr	ed to medicai					26 Pleas of	f Death (Check onl		1	7165 2010	
of Vita Physician: r this certific and director,	o Be	examiner?		Hospital:	patient 2	ER/Outpatient	3□ DOA	Other:	ing Home 5□Re		ner (Snecih	41	
	-	27. Menner of Death		28a. Date o (Monti		28b. Time of Injury	28c.	Injury et Work?	28d. Describ	e how injury occur		7	
Division I or Attending I after death. Director: After d in by the funer	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could n determi	ot be 28e. Place	of Injury - At he g, etc. (Specif	ome, ferm, stre			28f. Location	(Street and Numi own, State)	ber or Rura	l Route Number,	
To the Hospital of within 24 hours at To the Funeral Discompletely filled it	ai Ce	29s. Certifier	Contifying	Physician: To the I	pest of my kno	wledge, death	occurred at th	e time, date and p	placa, and due to the	ne cause(s) and m	anner as st	ated.	
he He in 24 he Fe	Medicai	one)	all wordical E	xaminer: On the ba and mann	er stated.	tion and/or inve	estigation, in r	ny opinion, deeth	occurred at the tim	e, date and placa,	and due to	the ceuse(s)	
To the within 2 To the comple	Σ	29b. Signature and	its of certifier				29c. Lic	cense number		29d. Date signe			
0		100	alse					D28656		March	h 3, 2	2000	
(1)		30. Name and addre	ss of person v	no completed cause	of death (Item econd A	123e) (Type, P	rint))4B; Silv	ver Sprin	g, MD 20	0910	1	
	tate		31. Date filed (Month, Day, Year) 32. Registrar's Signature S. South										
Regis	nti di	MAR	0 6 200	U Day	,,,	N. A	Dales	/					

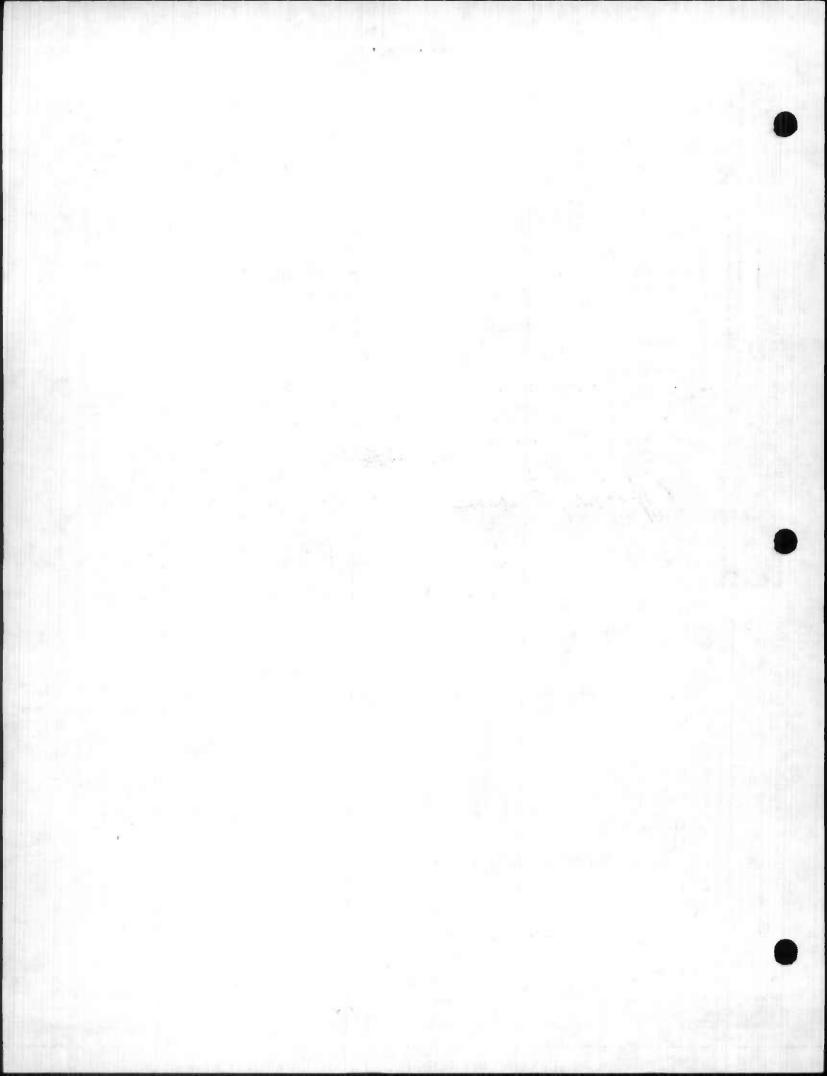
State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate	of Death		F	leg. No.	U	9820	
Dhari	-lau	1. Decedent's Nam	The second second	ast)					2	2. Date of Dea Month		Year	3. Time of Death	
Physic /Med		CHE	TER	VICTOR				3 13 2000			0940			
Exami		4a Facility Name (If not institution, gi	4b. City, Town, or Loc				4c. County						
- 4		A. G.	H.				I Williams 4 N	Borci			WORCE			
Funera Director		5. Social Sacurity N 209-16 Usual Residence of	- 4483	Sex 7.	Age (In yrs. 74	last birthday, Yrs.	Months D	ear If Under	Min.	B. Date of Birth (Month, Pay 2/5/26	Year)	9. Birthpi	lace (Stata or Foreig try)	
a wa		10a. State 10b. County 10c. City, Town or Location								10d. Inside				
Mary	tor	Mp.	WORCES	TER	В	ERLIN						1 Yes 2 No		
4 with the 3e or 28	ai Director	10e. Street and Nu	mber KTON LA	NE			10f. Zip Co			1	What Coun	try?		
5/6 $4 + 4/5$ 5 960 960 4 21215-0020 Switchin 72 hours after death with the Maryland siene. Then "natural", or thems 23a or 28e4 show the Maryland transmission or the mass of 28e4 show the Maryland transmission or the mass of 28e4 show the Maryland transmission or the mass of 28e4 show the Maryland transmission or the mass of 28e4 show the Maryland transmission or the Maryland tr	by Funeral	11. Marital Status 1 Never Marr	led 25 Married	12. Was Decedent Evar in U,S. Armed Forcas? 1 yas 2 No If Yes, Give Year or Dates:			13. Was Decedant of Hispanic Origin? (Spe If Yas, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:			ity Yas or No- ican, etc.)	14. Rac Blac Specify	ce - Amarican Indian, ck, White, atc. WHITE		
3/13/00 15-0020 72 hours at		02 111001100	15. Decedent's B			16a Dece	dent's Usual O	ccupation		1	16b. Kind of Br	usiness/industry		
	Completed		cify only highest g	est grade completed)		(Give	kind of work d DO NOT use r	lone during mos etired)	t of working	7	Too. Tand of Di	ob. Ning of Business/industry		
209 16 eased d 2121 flied within Hygiene. ort, fre wen	mo	Elamentary/Second 12	ndary (0-12)	College (1-4or 5+)		Su	PERVIS	SOR			SOAP	MF	GR.	
209 16 rcca5ed and 2121 be filed within that Hygiene. d other than	Be C	17. Father's Name	(First, Middle, Las	t)	JOI LIVIO				r's Name (First, Middle,	Maiden Suman			
	0	JOHN VICTOR LOUISE KATRA												
	-	19a. Informant's N				19b. Mall	ing Address (S	treet and Numbe	er or Aural	Route Numbe	r, City or Town,	, State, Zip Code)		
		MILDRE	o L. VI	CTOR		8 B	ROOKTO	ON LANE	BER	RLIN,	Mp. 21	1811		
O S THE STATE OF T		20a. Method of Dis		□Removal from Sta	20b. F	Placa of Disposametery, cre	osition (Name of matory or other	of r placa)		Date	20c. Location -	City or To	wn, State	
2/05/26 ? Baltimore, A Baltimore, A Department of Hailth Important: It items? any Injury or other to ance.		4 Donation	5 Other (Spec	ity)				REMATOR	RY 3-	-17	SALISE	BURY	MD.	
		21. Signature of Fu	need Service Lice	TAIL				ddress of Facilit		Номе	BERLIN	, MI	0. 21811	
		23a. Part Enter t	he disease, or cor	mplications that cau y one cause on eac	sed the deat	h. Do not en	ter the mode of	f dying, such as	cardiac or	respiratory ar	rast,		Approximate Interval Between Onsat and Death	
Physician		SHOCK, OF HER	it lendle. List on	y one cause on eac	ii iii ie.							- 1	Onsat and Death	
/Medical Examiner		Immediate Cause (Final disease or condition											MINS.	
		resulting in death)		a	Due to (d	or as a conse	quenca ot):						701100 1	
P #	lner		_	Antio	selevi	tú Co	Keliveck	when	An	un			YKS	
ocute and trans	me	Sequentially list conditions. The sequential by list conditions is a consequence of the sequence of the seque												
Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.												
68760, ficata be ax physician is the burial	dica	that initiated events resulting in death) Lest Due to (or as a consequence of):												
X 68	- 5			l d										
Box anth cer attendir	lan													
P.O. Box nat the death cert d by the attendin	Physician/	Part II. Other algnit	icant conditions	contributing to deat	h but not res	ulting in the u	underlying caus	e given in Part I					the cause of death	
IS, P.(as that th signed by be detact	Ph /	Status	FOST AN	MIC VALVE	Ry	lacera	rd.			101	res 2□ No	3 ☐ Prol	bably 4 Unknow	
d be	d by	.,	,		0					24a. Was	an autoosy	24b. We	era autopsy findings	
Cord v require been si	ete	Hyp	utensur	/							mad?	av	ailable prior to mpletion of cause	
II Rec	Completed	10										10.00	death?	
Vital Files. The certificate rector, page		Hyp	erlyndu	ш							es 2 SHO	1 L	Yes 2□ No	
Vit Ilclar Centif recto	Be	25. Was case efar examiner	/	Hospitel:				Othor		(Check only o		40. 14		
Physic ral din	-	1 Inpatient 2 Ethoutpatient 3 STOOA 4 Invising Homa 5 I Hesidence 8 I Ott									0			
On ding f		27. Manner of Deeth 28a. Date of Injury 28b. Time of Injury 38b. Time of Injury 40b. T												
Division of Vital Records, or Attending Physician: The law requires that death. Offector: After this certificate has been signed in by the funeral director, page 2 should be contained.	fica	3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office 28f. Location									Street and Number or Rural Route Number,			
Div.	Certification:	4 Homicide determined determined building, etc. (Specify)												
Division of Vita To the Hospital or Attending Physician: within 24 hours aftar death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C	29a. Certifier (Check only one)		hyaician: To the be iminer: On the basi and mannal	s of examina									
o the	Me	29b. Signature and	title of cartifier	,			29c. L	lcense number			29d. Date signe	d (Month,	Day, Year)	
F 3 F 3		1	Inceld T	M- lung A	B		Λ	10688			2/2	1/0		
		30. Name and addr		/		n 23a) (Tvre		0600			2/61	700	Y, MO	
77	41	7		· Wood	MD	400	2000	TRN SH	ONE	DUNA	540	BAUR	Y, NO	
	tate	31. Date filed (Mon			istrar's Signa						1		1/00/10	
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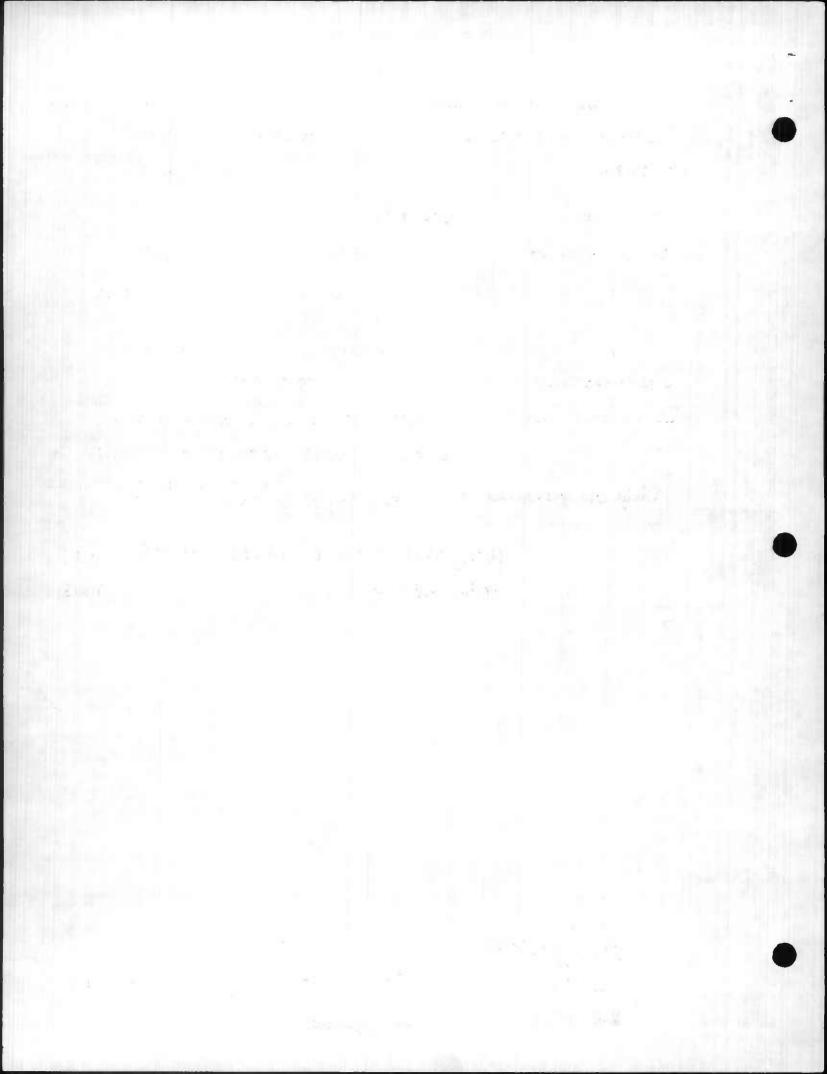


State of Maryland / Department of Health and Mental Hygiene 00 09821

Physician		JUNE E						2. Date of Deal Month	Dey Year			a of Death					
edical miner	4e Facility Neme (If not institution, give street and number)									4b. City, To	wn, or Lo	cation of Death		y of Death	4.	30 AIV	
	52 Newport Dr.								Ocea			Worcester					
Funeral Director		5. Social Security Number 379-32-5700 Usuet Residence of Decedent						Months			Min.	8. Dete of Birth (Month, Day) 6/30/	Year) 13	9. Birtho	ichic	te or Foreign jan	
is, or sens 23s or 23s-1 show taminer roust be notified at by Funeral Director	10a. S	-	10b. County			10c. Ci	ty, Town or L	ocation						1	Od. Inside	City Limits	
		MD	Wor	ceste	r		Ocean	Pin	es			1 🗆 Ye					
										1	0g. Citizen of USA	of Whet Country?					
	1[11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced			12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:			13. Wes Decedent of Hispanic On If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☐ Specify			gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)	Ble	14. Race - American Indian, Bleck, White, etc. Specify: White			
pete		15. Decedent's Edu (Specify only highest grad						edent's Usu	ual Occup	pation during mos	of work	ina	16b. Kind of E	Kind of Business/Industry			
Completed	Ele	Elementery/Secondary (0-12)			College (1-4or 5+)			(Give kind of work done dur life. DO NOT use retired)					Title Co				
	17 F	17. Father's Nema (First, Middle, Last)			2 Abstra			Clor	18 Mothe	r's Name	/First Middle I		Title Co.				
o Be											er's Neme (First, Middle, Maiden Sumame) ertha Zinnecker						
T			me/Relationshi			ghter		_			umber or Rural Route Number, City or Town, State, Zip Code) Ocean Pines, MD 21811						
	1		osition Cremetion : 5 Other (Spe		vet from Sta	ate	Place of Disponentery, cre	ematory or	other pla		eter	/15/00	20c. Location - City or Town, State Caro, MI				
	-		neral Service Li		, ,	0		2. Name a	ind Addre	ess of Facilit	y E	Burbage Berlin,	Funer	al Ho	me		
	Imme	dieta Cause (I	Finel	complication only one car	ns that cau	ed the deat line.	th. Do not en				cardiac (or respiretory arr	est,		Approxir Interval Onset a	mete Between nd Death	
Medical Examiner	Sequif any cause Caus that in		Finel nditions, mediate nying injury	c	ns that cau	Due to (c	th. Do not en	equence of	de of dyi		cardiac (est,		Interval	Between	
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Amended Item #26, Per Phy., 03/10/2000, Carroll County, cew Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Deeth Month Dey **Physician** Amelia Theresa Vacca 6 2000 March 8:00pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Sykesville Carroll Continuum Care at Sykesville If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) Deys Hours 1 M 2 XF 81 218-01-4740 Yrs. Director Dec 28 1918 Md Usuel Residence of Decedent the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show Md Carroll Sykesville 1 X Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 21784 7309 Second Avenue USA death Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours aftar can of Health and Mental Hygiene.
Int: if item 27 Is marked other than "natural", or iter
ITY or other traumatic event, me legicial Exercise.
ITY or other traumatic event, me legicial Exercise. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: by 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coilege (1-4or 5+) Eiementery/Secondery (0-12) domestic homemaker 6 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Dominic Cardinale Sophia Mazagato 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Ron Vacca (son) 4215 Winding Way, Westminster, Md 21157 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any Injury or c 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 3-10-2000 Marriottsville, Md 22. Name end Address of Fecility 21. Signeture of Funerei Service Licensee Haight Funeral Home & Chapel Paige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician acripheral occlusive vascular disease Immediete Ceuse (Finel disease or condition resulting in death) /Medical Examiner Examine physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) 50 attending p esn signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed certificate has b irector, page 2 s 2 1 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificaletaly filled in by the funeral director, 25. Wes case referred to medical examiner? Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner as stated. within 24 ho To the Fune completaly fi Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted. 29b. Signature and 29c. License number 29d. Dete signed (Month, Day, Year) 0 03-10-00 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Owings Mills MD 21117 10085 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture State Registrar MAR 1 0 2000



State of Maryland / Department of Health and Mental Hygiene 09823. AMEND# 9 3/6/00 AACO Health CMH Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Paul Elonzo Woodie, Sr. 2, 2000 9:50 pm March /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Sunrise Assisted Living 8. Data of Birth (Month, Day, Year)
Jan 4, 1912 N. Caroline If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpleca (Stata or Foraign Funeral Months Days 15M 20 F Hours 241-24-1706 88 Director Usual Residence of Decedent Carolina 10n State 10b County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at Baltimore Baltimore 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 9502 Old Harford Road 21052 USA Herna 23a death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 14. Race - Amarican Indian. Black, White, atc. 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0020 "natural", or White 1 Yas 2 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry 12 should be filled within 72 is and Mental Hygiene. Is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) Engineer Engineering 12 Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Pages 1 and 2 should be Charles E. Woodie Isabell Dancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Health and Important: If Nem 27 is m any injury or other traum 1065 Sun Valley Drive, Annapolis, MD Paul Woodie, Jr. / son Baltimore, 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Malate 1 Burial 2 Cremation 3 Removal from Stata
4 Dogation 5 Other (Specify) Baltimore, MD Moreland Memorial Park 2000 21. Signature of Funeral Service Licen 22. Nama and Addrass of Facility Barranco & Sons, P.A. Severna Park Funeral Home her caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, A 21146 Approximata Intarval Batween Onset and Death Physician /Medical ediate Cause (Final sease or condition Examiner Examin leading to immedia Enter Underlying (Disease or inter-Box 68760 Physician/Medical that initiated events resulting in death) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? Records, P.O. t Yee 2 No 3 Probably 4 Unknown ò 24b. Were eutopsy findings available prior to completion of causa of death? 24e. Wes an autopsy performed? Completed 1 Yas 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: 1□ Yes 2No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manager of Dea 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Watural 5 Pending Accident 1 ☐ Yas 2 ☐ No investigetion n 24 hours after death se Funeral Director: J cletaly filled in by the 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide 8 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie To the 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 3-3-2000 Severna Park Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Data filed (Month, Day, Year)

MAR 0 6 2000

32. Registrar's Signature

HAR O S YOUR SEASON

State of Maryland / Department of Health and Mental Hygiene 00 09824

						Cei	rtificat	e of	Death			Reg. No.			
		1. Decedent's Name (Fire	st, Middle, La	st)							2. Date of De	ath	V	3. Tir	ne of Death
Physician		George	Stev	vart W	haley,	Jr.					03/ 0	Day 5/2000	Year 0	9:3	O AM
/Medica Examine		4a Facility Name (If not in							4b. City, To	wn, or Lo	ocation of Deat		ounty of Deat	-	
		Hebrew Hon	ne of (Greater 1	Washin	gton		F	Rockvi	11e		Mont	tgomery	7	
Funeral Director		5. Social Security Number 267-24-974	r 6. S						24 Hrs. Min.	8. Date of Bir (Month, De 05/28/				ate or Foreign	
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72 ho	201		Decedent's Ed	ducation ide com <i>pleted</i>)		16a. Dece	dent's Usu	ai Occup	ation	t of work	ina	16b. Kind	of Business/	ndustry	
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Mental Mental arked o	0	George Ste	Sr.				G1a	dys	Givens						
d 2 should be file th and Mental Hy 7 is merked oth treumatic event		19a. Informent's Name/P	elationship (Type, Print)		19b. Maili	ng Addres	s (Street	end Numb	er or Rur	al Route Numb	er, City or	Town, State, Z	(ip Code)	
nd 2 aith a 27 is		Adrian Wha	ley /	Son		28 P	utter	Dr.	, Wal	ling	gford,	CT O	6492		
permitting of the property of the property of the permitting of the permitten of the permitting of the permitten of the permitting of the permitting of the permitting of the		Adrian Whaley / Son 28 Putter Dr., Wallingford, CT 06492 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Localion - City or Town, Stete Double Company or other place Metropolitan Crematory Alexandria, Virgosition Crematory Company Co													
permit. Pe Depertment Important: eny injury	-	21. Signature of Funeral			2600	22	. Name ar Adven	nd Addre	s of Facili	ty & (Cremati	on Sei	rvices		
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requires that the death certificate be executed seen signed by the attending physician end mould be deteched for use as the bunal-transit	Ceuse (Disease or injury that initiated events resulting in daath) Last Due to (or as a consequence of):														
ath ce ath ce for us	9	U.													
the attend thed for us	Completed by Physician	Part ti. Other etgnificant	conditions c	ontributing to death but not resulting In the underlying cause given in Part I.						i.	23b. Did	tobacco u	se contribute	to the ca	uee of death
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aw aw											Was an autopsy performed? 24b. Wera autopsy available prior completion of of death?			orior to	
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Physicien: this certific ral director,)	1 Yes 2 No	-	Hospital: Other:						ursing Ho	g Home 5 ☐ Residenca 6 ☐ Other (Specify)				
nding Pheth. T. After the funeral		27. Manner of Death Natural 5 □ 2 □ Accident	5 Pending investigation		28a. Date of injury (Month, Dey Year) 28b. Time of Injury Work? M 28c. Injury at Work? 1 Yes 2 No					28d. Describe how injury occurred					
To the Hospital or Attending Physicien: The I within 24 hours effer deeth. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or F City or Town, State)									ural Route	Number,				
To the Hospital within 24 hours to the Funeral completely filled	caicai	29a. Certifier 12 ((Check only 2 1	Certifying Ph Medical Exam	yaician: To the b ninar: On the bas and manne	is of examina	wiedge, deat tion and/or in	h occurred vestigation	at the ti	me, date ar opinion, dea	nd placa, ath occur	and due to the red at the tima	cause(s) a date and p	nd manner es place, and due	stated. to the ca	use(s)
Within To the comp		29b. Signature and title of confilmer MD. 29c. License number D. O. 18089 MARCH 05, 20 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) D. D. PATEL, M.D. 612 1 MONTROSE RD, ROCKVIUE, MD 20852									h, Day, Ye	ear)			
		30 Nama and address of	Derson who	Old N	of death (list	n 23e) /T-mc	Print)	1) 6	00/0	508	9	MARC	CH 05,	200	00
		30. Nama and addrass of	ATEL,	M.D. 6			Ro52	RE	, Roc	KVI	uE M	020	825		
State		31. Date fited (Month, Da	y, Year)	32. Re	gistrar's Signa	ature		1							

ded to

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Lillian Edith Williams 4:35 AM February 29 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis
| If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 3254 Harness Creek Road Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Months 91 Director 212-52-3518 Feb. 3, 1909 Maryland Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d, Inside City Limits show r than "natural", or hams 23s or 28s-f shorthe the shorthe than the motified at 1 ☐ Yes 🏋 No Maryland Anne Arundel Directo Annapolis 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 3254 Harness Creek Road 21403 United States Funeral permit. Pages 1 and 2 should be filled within 72 hours after dea Department of Health and Mental Hygiene. Important: if them 27 is marked other the any injury or other trauser. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 Never Married 2 Married 1 Yes 21 No Specify: Specify: White à 3€Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be John Henry Jacobs Mary Elizabeth Drury 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Christo (daughter) 710 American Drive Annapolis, MD. 21403 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Cemetery 3-2-2000 Annapolis, MD. Service Licensee John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Metastatic Cancer of unknown primary /Medical Examiner Examiner physician and s the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Hyperfension, Staphorn Menel Calculer 1 Yes 2 No 3 Probably 4 Unknown should be dete Records. þ The lew requires 24b. Wera autopsy lindings evailable prior to Be Completed Atrial Fibrillation 24a. Wes en eutopsy completion of cause of death? 1 Yes 250 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of D 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and lifts of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew G. Gordon, M.D. 2003 Medical Parkway Suite 100 Annapolis, MD. 21401

DHMH 16 Rav 6/95

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 1 2000

32 Registrar'a Signature

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1885 (1886) 3. A.M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Daath ATSON 26 2000 Feb Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Gen dospita Irs. 8. Dete of Birth (Month, Day, Ye March 15, rundel 5. Sociel Security Number If Under If Under 24 Hrs. 7. Age (In yrs. last birthday) Yeer 9. Birthpleca (State or Foreign Caustry) West Virginia Months Deys Hours Min. 1□ M 2\ F 578-24-6210 76 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 477 Broadneck Road 21401 USA 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorcad White 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Robert Howard Ethel (Unknown) 19e. Informent's Nema/Relationship (Type, Print) 19b. Melling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Bill Frye/Son 1097 Sea Holly Ct. Virginia Beach, Virginia 23454 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other piece) 20c. Location - City or Town, Stete 1 ABuriai 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Crownsville Veterans Cemetery 03-01-00 Crownsville, Maryland Servica Licansee 22. Neme end Address of Fedlity John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Md. 21401 23a. Part1. Enter the disaasa, or complications that caused the daeth. Do not enter tha mode of dying, such as cardiec or respiratory errest, shock, or heer feilura. List only one ceuse on aech line. Approximete Interval Between Onsat end Death Immediata Cause (Finel disaase or condition resulting In deeth) 1NKHOW. pertensive Sequentielly list conditions, if eny, laeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings evaileble prior to completion of cause of death? 24a. Wes an eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No.

Physician /Medical Examiner

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The law requires that the death certificate be executed

or Attending Physician:

Hospital hours Funerai

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Division of Vital Records, P.O. Box 68760,

Department of Health e important: if Item 27 is any injury or other traconce.

Physician

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28a-f show

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traumatic event, the Medical Examiner must be notified at

with the Maryland

filed within 72 hours efter death

Peges 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: if Nem 27 is marked other than '

Baltimore, Maryland 21215-0020

Physician/Medical þ Completed Be 2 Certification:

26. Place of Deeth (Check only one)

25.	wes	case	perreter	to	medical	
	exam	iner?				
	100	es.	2 \ No			

27. Menner of Death

1 Inpatient 28e. Date of Injury (Month, Dey Year) 5 Pending Investigation

2 ER/Outpatient 3□ DOA 28b. Tima of

28c. Injury at Work? 1 Yes 2 No

America

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a, Cartifier

1 Neturel

2 Accident 3 Suicide

4 Homicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to tha causa(s) and mennar as steted.

Madical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner steted

29b. Signeture and title of cartifier

Deputy

06054

29d. Dete signed (Month, Dey, Year)

e and address of person who complated gauge of death (Itam 23a) (Type, Print)

ON MD

2000

31. Dete filed (Month, Day, Year) State Registrar

MAR 0 1

32 Registrer's Signature

DHMH 16 Bey 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		Certificate of Maryland / Department of		Reg. No. 09827						
	Di	Decedent's Nama (First, Middla, Last)	2. Data of I							
4	Physician /Medical	DANI MELITIC TIT	FEB.	25 2000 2:35 pm						
	Examine	4e Facility Name (If not Institution, giva street and number)	4b. City, Town, or Location of Dec	ath 4c. County of Death						
_		ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS	ANNE ARUNDEL						
L	Funeral Director	5. Social Security Number 2 1 9 - 5 8 - 3 6 6 9 Usual Rasidence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 4 8 Yrs. #Under 1 Yas Months Day	s Hours Min. (Month, I	9. Birthplaca (Stata or Foraign Country) 21 1952 MARYLAND						
	Pand Man	10a. Stata 10b. County 10c. City, Town or Location		10d. fnside City Limits						
	Man of	MARYLAND ANNE ARUNDEL ANNAPOLIS		1 XYas 2 No						
	with the Maryland a or 28a-f ahow be notified at	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?						
	23a c		3	USA						
	r items 234	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Marital Status 15. Armed Forces?	Hispanic Origin? (Specify Yes or I ban, Mexican, Puerto Rican, atc.)							
Maryland 21215-0020	Mr	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☑ No.		Specify: black						
5		15. Decedent's Education 16a. Decedent's Usuel Occ (Specify only highest grade completed) (Giva kind of work don	upation e during most of working red)	16b. Kind of Businass/Industry						
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and	SED A		HENRIETTA C							
2				nber, City or Town, Stata, Zip Code)						
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re,	- P E E	20a. Mathod of Disposition 20b. Place of Disposition (Nama of	Data	20c. Location - City or Town, Stata						
E	Peges nert of nrt: If its nry or o	1 Burial 2 Cremation 3 Removef from Stata 4 Donation 5 Other (Specify) ANNAPOLIS MEM.		2000 ANNAPOLIS, MD.						
Baitimore,	当者を	21. Signature of Funeral Service Licensee 22. Nama and Add	ress of Facility							
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		23a. Part1. Entar tha digease, or complications that caused the death. Do not entar the mode of dishock, or heart failure. List only one cause on each line.	ST. ANNAPOLT: ying, such as cardiac or respiratory	Approximata Interval Between						
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	/Medical	Immediata Causa (Final disaasa or condition a. Septic Shack								
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	arecuted in and itel-transit	b	- 144							
_6	physicien and stransit sthe burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								
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o.	the day the sched	Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa of		id tobacco use contribute to the cause of death?						
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00	as bee 2 sho	Renal tailing	pe	rformed? available prior to completion of cause of death?						
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Division	tal or Attanding P rs after death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be detarmined 28e. Place of Injury - At homa, farm, street, lactory, office building, etc. (Specify)		(Street and Number or Rural Route Number, Town, Stata)						
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	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification.	29a. Certifier ☐ Certifying Physician: To the best of my knowledge, death occurred at that (Check only one) ☐ Certifying Physician: To the best of my knowledge, death occurred at that in the basis of axamination and/or invastigation, in my and manner stated.	tima, data and place, and due to the opinion, death occurred at tha time	ne cause(s) and mannar as stated. e, data and place, and due to the cause(s)						
	Me other	The state of the s	nse number	29d. Data signed (Month, Day, Year)						
	H # F O	· // //	C5187	2/25/00						
		30. Name and address of person who completed cause of death (Item 23s) (Type, Print)	DR.Geokge Yu	4						
		64 E State Annual	MO	21401						
	State	31 Date Must (Month, Day, Year) 32 Registrar's Signatura	1							
	Registrar	MAR 0 2 2000 Jenera B. span	W Comments							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death February 28, 2000 **Physician** 11:45 am HOWARD WENTWORD WHEELER /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr 12, 1913 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** 215-05-5305 1X0 M 2□ F 86 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 1 ☐ Yes 2 ☒ No Director 288-1 10e. Street and Number 602 McKinsey Park Drive, Unit 501 21146 10g. Citizen of What Country? ð USA 23a Funeral or Nems 12. Was Decedent Ever in U,S. Armed Forces?

1 Wes 2 No WWI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant if them 27 is marked other than "natural", or its ary or other treumatic event. the Medical Examins 1 Never Married 2 Married WWII White 21215-0020 1 ☐ Yes 2 No Specify: Specify: p 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Architect Architecture 5+ Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oscar Joseph Wheeler Sarah Jay Wentworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 125 Hatton Drive, Severna Park, MD Judith O'Malley / daughter Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Mar 3 2000 20s. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Department of Important: If 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Europeal Service License 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146
Approximate
Approximate Physician Immediate Cause (Final disease or condition graditing in death) Due to (or as a consequence of): Examiner REPS15 Physician/Medical Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Box 68760 Cardiomyo Schemic Due to (or as a consequence of): myocardist Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of de-Records, P.O. 3 Probably 4 D€nknow 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy this certificate has 1 Yes 2 LINS 1 □ Yes 2 □ No of Vital 88 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 SNO 27. Manner of Death edical Certification: 28b. Time of 26c. Injury at Work? 28d. Describe how injury occurred Attor Division 5 Pending investigation 1 Wetural if or Attending a shor death. 1□Yes 2□No 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 C Homicide To the Hospital of within 24 hours a To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis MO the lenter 31. Date filed (Month, Day, Year) 12. Registrer's Signature State MAR 0 3 2000 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician 01 Fabruary 23 2000

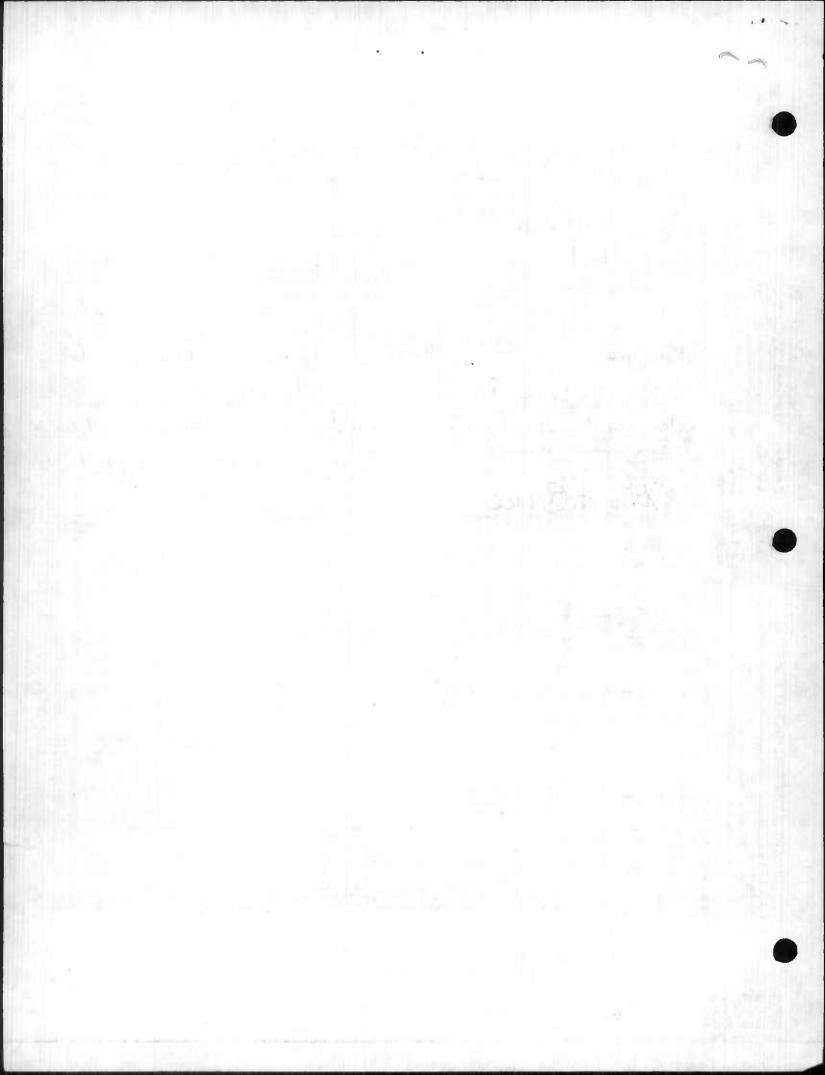
4b. City, Town, or Location of Deeth 4c. County of Death 9137 P.M. /Medical 4a Facility Name (If not institution, give street and number) Examiner FRANKLIN SQUARE HOSDITAL CCF 5. Social Security Number 0 6. Sex 7. Age (In yrs. last birthday) Kosedale If Under 24 Hrs. 8. Det BALLIMORE CenTer birthday) If Under Months 8. Dete of Birth (Month, Dey, Year) **Funeral** Days Hours 1 M 2 F Director Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits -how rall, or items 23s or 28s-f shore Examples must be notined at 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? TAND had 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give/ Year or Dates: 14. Race - American Indian, Black, White, etc. "netural", or items 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 his Department of Health and Mental Hygiana. Important: If Itam 27 is marked other than "nature any injury or other traumatic event, the Medical pages. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) rackaging Perator 18 Mother's Name (First, Middle, Maiden Surname) 8 610N JONES She 100 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) raddock (00) altimora 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 2-29-00 Venton 4 ☐ Donation 5 ☐ Other (Specify) tary eme. no of Americal Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 917 Isabelle St. enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory enest. PaG Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel erebe disease or condition resulting in death) DAY Examine Due to (or as a consequence of): Examiner emia The law requires that the death certificate be associted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, COAGULOPATHY SECONDARY TO Physician/Medical signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23h. Did tobacco use contribute to the cause of death? 1 Yaa 20 No 3 Probably 4 Unknown Hyper lension Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Value Replacemen 25. Was case referred to medical examiner?

1 Ves 2 No 1 Yes 1 ☐ Yes 2 ☐ No DISCASE or Attending Physician: 8 26. Place of Death (Check only one) Hospital: 10 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Sid 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No 2 Accident investigation ofter doeth Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours effar de To the Funeral Directo complataly filled in by th Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) ins Park 2000 Tebruary 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21237 PARK 9000 FRANKlin QUARE DR. ChRIS BALTIMORE, 32. Pégistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 1

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hyoiene 1 1 9830

Medical Raminer	Decedent's Nama (First, Middle, L ARTHUR Facility Nama (If not institution, p.	ast)				_						
neral	4a Facility Nama (If not institution, or			WILSON	V	e			Data of De Month FEB	13, 200	Year O	3. Time of Death 11:25 AM
eral						- 4	4b. City, Town					
lerai	Salisbury Center; 5. Social Security Number 6.			last birthday)	If I Inde	r 1 Year	Salis If Under 24	_			omico	
	220-12-1243 Usual Residence of Decedent	18 M 2□ F	86	Yrs.		Days		Min.	(Month, Da	y, Year) 27,1913	Count	laca (Stata or Foraign try) LAND
-	10a. Stata 10b. County		10c. Ci	ty, Town or Lo	cation						10	Od. Inside City Limits
ģ	MARYLAND WICOMIC	CO		MARD	ELA	SPRI	NGS					1 □ Yas 2 □ No
3	10e. Street and Number				10f. Zi	p Code				10g. Citizen of V		itry?
	10355 SNETHEN CHI					218					S.A.	
by Funeral	11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Force 1 Yas 2 If Yes, Give	Ø No				lispanic Origir an, Mexican, I Specify:	n? (Speci Puarto Ri	fy Yas or No can, atc.)	Specify	e - Amarica ck, Whita, a	
	15. Decedent's F	ducation	9 0.	16a. Deced	lent's Usu	al Occup	etion	-		16b. Kind of Bu	-	
Completed	(Specify only highest gi	rade completed) College (1-4	lor 5+)	(Give	kind of wo DO NOT u	ork done	durina most a	l working		WICOMIO		
	17. Father's Nama (First, Middla, Las	()					18. Mother's	Nama (First, Middla,	Maiden Sumam	na)	
o Be	CHESTER ARTHUR	WILSON					EMMA	BEI	NNETT			
	19a. Intormant's Name/Relationship	(Type, Print)		19b. Mailin	g Addres	s (Street	and Number	or Rural I	Routa Numbe	er, City or Town,	Stete, Zip	Code)
	REBECCA A. WILSON	V - WIFE					N CHUR	CH RI	O. MA	RDELA SI	PRING	S, MD 2183
2	20a. Mathod ot Disposition 1		. 6	Place of Disponentery, crem INGHILI	netory or	other plac	GARDEN		Data 16/00	20c. Location · HEBRON		wn, Stata
	Signature of Funger Service Local Servi	Alm	used the deal ch line.	SP BO	UNDS	FUNI		rdiac or i	raspiratory a			MD 21804 Approximate tritarval Between Onset and Death
	Immediata Causa (Final diseasa or condition resulting in death)	· con	Due to (or as a conseq	uence of)	enf las	Jac	las				ndalle
Ical Examiner	Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disassa or injury that initiated evants	c. De	on la	oras a consequence as a consequence								in.
8	rasulting in death) Last	d										
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Completed by										an autopsy rmed?	ava cor	ara autopsy findings silable prior to mpletion of cause death?
Eo									10	Yas 2 No]Yas 2□ No
	25. Was casa rafarred to medical						26. Place o	Deeth (Check only o	ona)	1	
0	axaminer?	Hospital:	patient 2	ER/Outpatien			442 Nurs	ing Home	5 🗆 Rasio	dence 6 🗆 Oth	ar (Specify	y)
	27. Manner d Deam 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident invastigetic	on	Injury Day Year)	28b. Tima of Injury	м	28c. Injur Wor 1 🗆	yat k? Yes 2 □ No		d. Describe I	how injury occur	red	
Certification:	3 Suicide 6 Could not l	26a. Place o	l Injury - At h , etc. (Specif	ome, farm, str	et, fector	y, office		28	28t. Location (Street and Number or Rural Route Number, City or Town, Stete)			

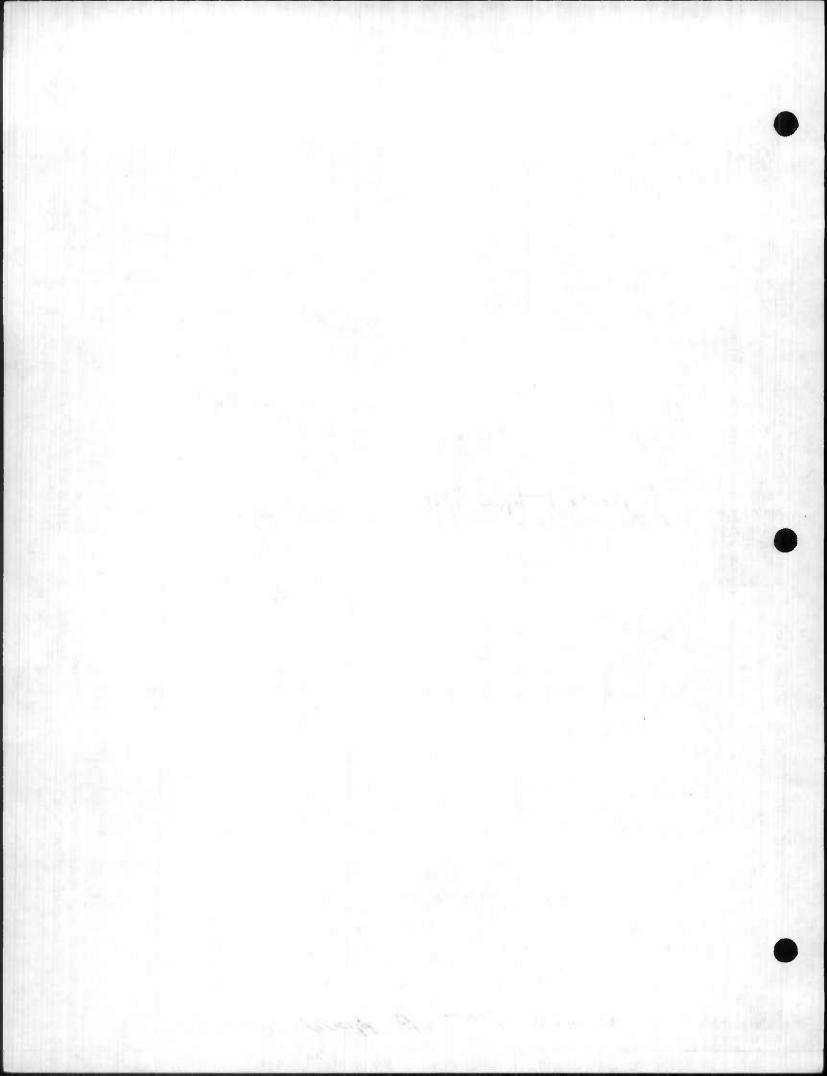
State Registrar

31. Data tiled (Month, Day, Year) FEB 15 2000

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY,

D-29349

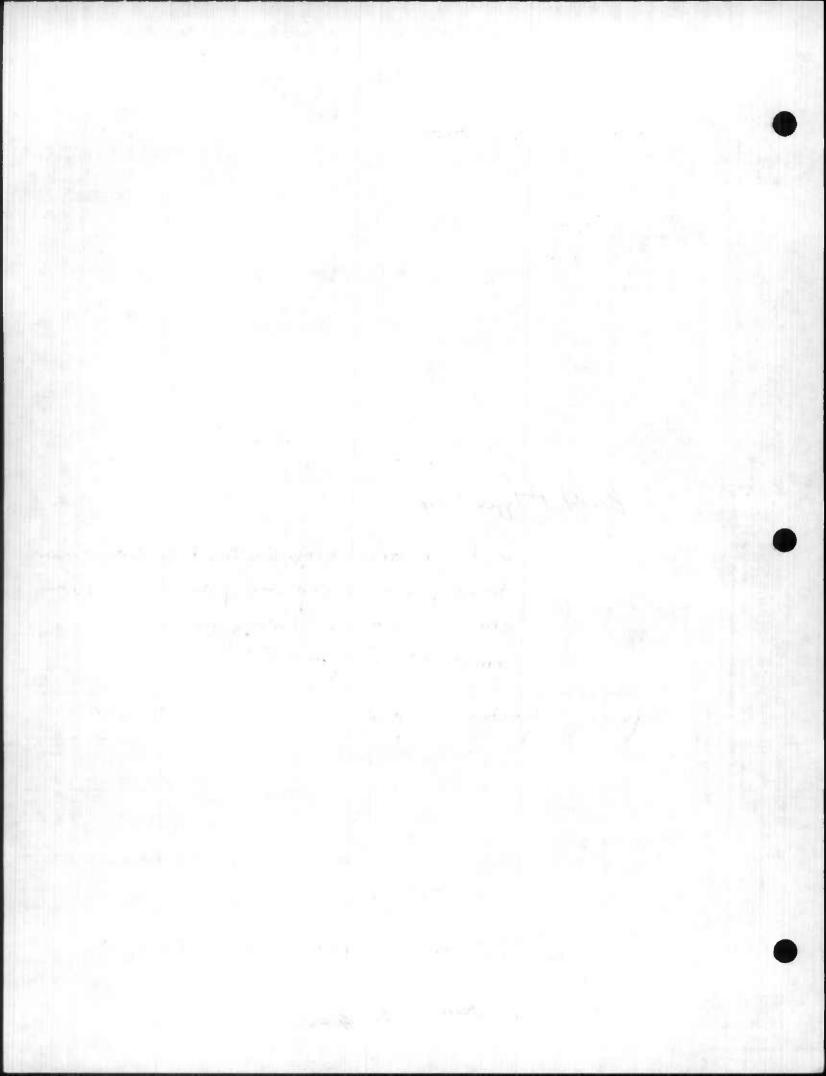


State of Maryland / Department of Health and Mental Hygiene

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				Cei	tificate of	Death			Reg. No.		3001
Dhunining	Decedent's Neme (First, Midd	die, Last)					100	2. Date of De	path Day	Yaar	3. Time of Death
Physician /Medical	MARVIN F	WILLIA	AMS, SR.					Febru		2000	0930
Examiner	An English Mann Mant Institution			ER			wn, or Lo	cation of Deat	,	of Deeth	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Yea		24 Hrs.	8. Date of Bir	th	9. Birthplac	e (State or Foreign
Director	217-10-2362	1Å M 2□ F	82	Yrs.	Months Deys	s Hours	Min.	8. Date of Bir (Month, De AUG . 2	3,1917	Country, MARYLA)
Pul *	Usuel Residence of Decedent 10a. Stete 10b. Count	v	10c. City.	Town or Lo	cation					104	Inside City Limits
death with the Manyland me 23s or 28s-f show ment be notified at				ISBUR						100.	1 □ Yas 2X No
\$ 50 E	10e. Street and Number				10f. Zip Code				10g. Citizen of 1	Whet Country	?
th wi	27306 NANTICOKI	E RD			21	801			U.S.A.		
- H - H - H		rried Armed F	cedant Evar in U,S. Forces? 2 No Give		Wes Decedent of 1 Yes, specify Cu 1 ☐ Yes 2 No			ecify Yes or No Rican, etc.)	Specify	ce - Amarican ck, Whita, etc	
Dour Pour	3 Widowed 4 Divorce									WHIT	
1 21215-002C ed within 72 hours at systeme. Per than "natural", or it, the Woden Earn	15. Decede (Specify only high	nt's Education est grade completed College	(1-4or 5+)	(Give life. L	lent's Usuel Occu kind of work done DO NOT usa retir	e during mos red)	t of worki	ng	16b. Kind of B	usiness/Indus	itry
21 Maria	10			PARTS	MANAGER				FARM E	QUIPMEN	T
be filed that dother event, Ba Co	17. Fether's Neme (First, Middle	, Last)				18. Motha	r's Neme	(First, Middle	, Maiden Suman	na)	
Maryland d 2 should be file th and Mental Hy 7 is marked other traumatic event		LIAMS				MARY	ELI	ZABETH	PARKE	2	
S should be made to a man of the	19e. Informent's Neme/Reletion	ship (Type, Print)		19b. Meilin	ng Address (Stree	et end Numbe	er or Rura	I Route Numb			ode)
A PER AN A	CATHRYN K. WILI	TAME - IJI	ree	2720	6 NANTTO	OVE DE		AT TODII	DM MD (11001	
Hear Hear	20a. Method of Disposition	LIAMS - WI	20b. Pie	ce of Dispo	6 NANTIC sition (Name of		1. 5	Dete	RY, MD 2		State
Baltimore, semil. Pages 1 ar separtment of Hea mportant: If Hem 2 morting or other more.	1 Burial 2 ☐ Cremation		n Stete		netory or other pl		1	- 4 - 4 -		,	
tin tame	4 Donation 5 Other (SPR		LL MEMOR			2/17/0		ON, MAF	
Balti permit. Departm importar any inju	21. Signature of Funerel Service	Licensee)	22	. Name and Add	rass of Fecilit	ty		705 E.	MAIN S	ST.
m 40249	D. Keel	X H hour	was CF:	50 B	OUNDS FU	NERAL	HOME	. INC.	SALISE	BURY, M	D 21804
	23a. Pert1. Enter the diseese, of shock, or heert teilure. Lis	r complications that	caused the deeth.	Do not ent	er the mode of dy	ing, such es	cardiec o	or respiratory a		A	pproximate iervei Between
X 68760, antificate be assecuted fing physician and sees the burnel-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	C b. 3	Due to (or e Due to (or e None Due to (or e	os a consequence of the conseque	uence of):	as pri	who when	o produ	or of or		2 www.
× 5 5 5		d. C	hymne	atru	of to	m v	W_				
O. Bo. Be death the attenthed for u	Part II. Other eignificant conditi	lons contributing to	death but not result	ing in the u	nderlying cause g	iven in Pert I		23b. Dld	tobacco uee co	ntribute to th	e cause of death?
es that the death control of the strent be detached for u	Ly hu	x fre	for 4	gu	NR.			10	Yes 2000	3 Probab	oly 4 Unknown
cord requir been s should	- '	0 1	PL	,				24a. Wes	en eutopsy ormed?	availa	autopsy tindings able prior to eletion of cause ath?
Vital Relations The law certificate has rector, page 2	Later Pro-							10	Yes 2 KNo	10	'es 2□ No
Vital Rysiden: The is certificate his director, page		ai l				00 Pt	1 C)1h			101	63 263140
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Of Vita Physicien: this certific ral director,		28e. Dete	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW	R/Outpatien	t 3LI DOA	4LINU	-		idence 8 Oth		
Sing Physical distribution: To Hion: To	1 Neturei 5 □ Pandi	ing (Moi	nth, Dey Year)	Injury		ury at ork?		200. Describe	now injury occur	100	
Division or Attending after death. Director: After d in by the fune	2 Accident invest	tigetion			M 10	Yes 2					
IVI IVI In IV	4 Homicide determ	mined 286, Plec	e of Injury - At hom ding, etc. (Specify)	e, ferm, str	eet, fectory, office	9	1		(Street and Numl wn, Stete)	ber or Rural R	loute Number,
O Section of											
Division of the Hospital or Attending Physician 24 hours after death. To the Funerel Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier Certifyi (Check only one)	ng Physician: To th Examiner: On the band man	e best of my knowle basis of examinetion	edge, deeth n and/or inv	occurred et the vestigetion, in my	time, date en opinion, dee	d place, a th occurre	and due to the ed at the time,	ceuse(s) and modete end piace,	enner as state end dua to th	ed. la cause(s)
Me Me	29b. Signature and title of certific	A			29c Licer	nse number			29d. Dete_signe	d (Month De	v. Year)
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		0			1	1			2/17	1~	
6	30. Neme and address of person	who completed cau	use of death (Item 2	3e) (Type,	Print)						
3	Joseph B		M.D.	-2. III							
State	31. Date fited (Month, Day, Year		Registrars Signetur	re	1. 1						
Registrar	FEB	1 5 2000	pener	_	6. So	ash)	//				

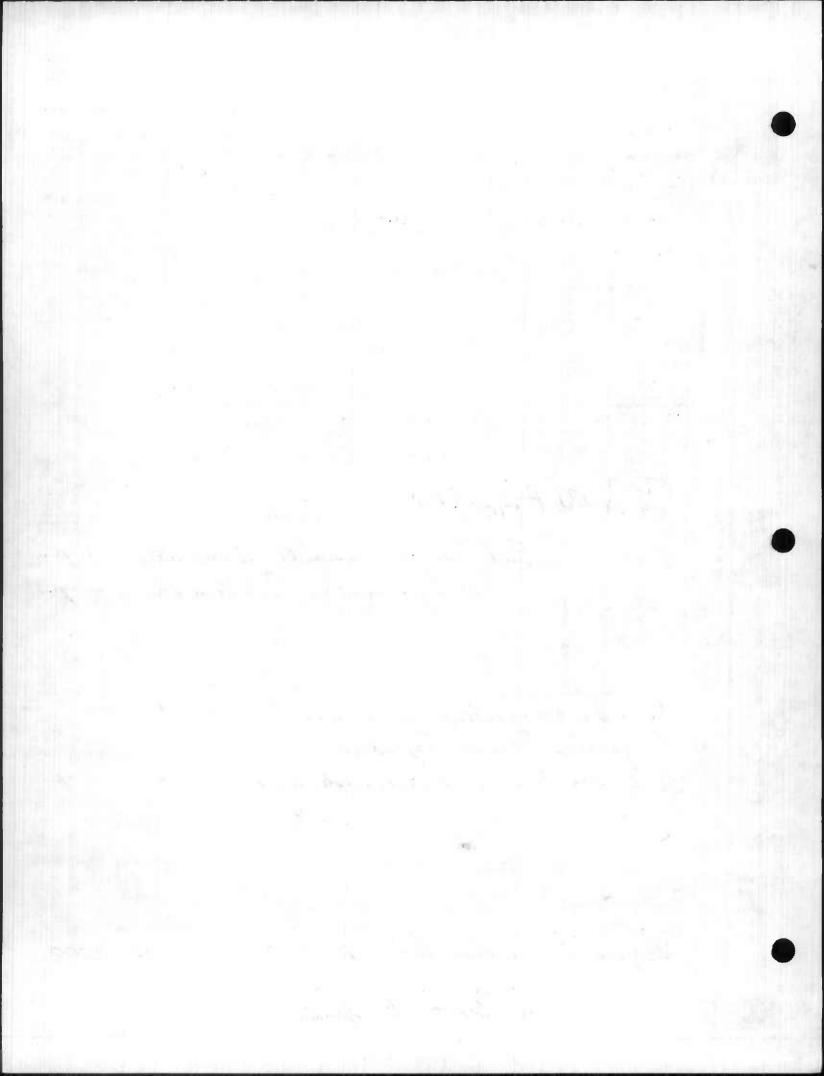
Marvin Williams



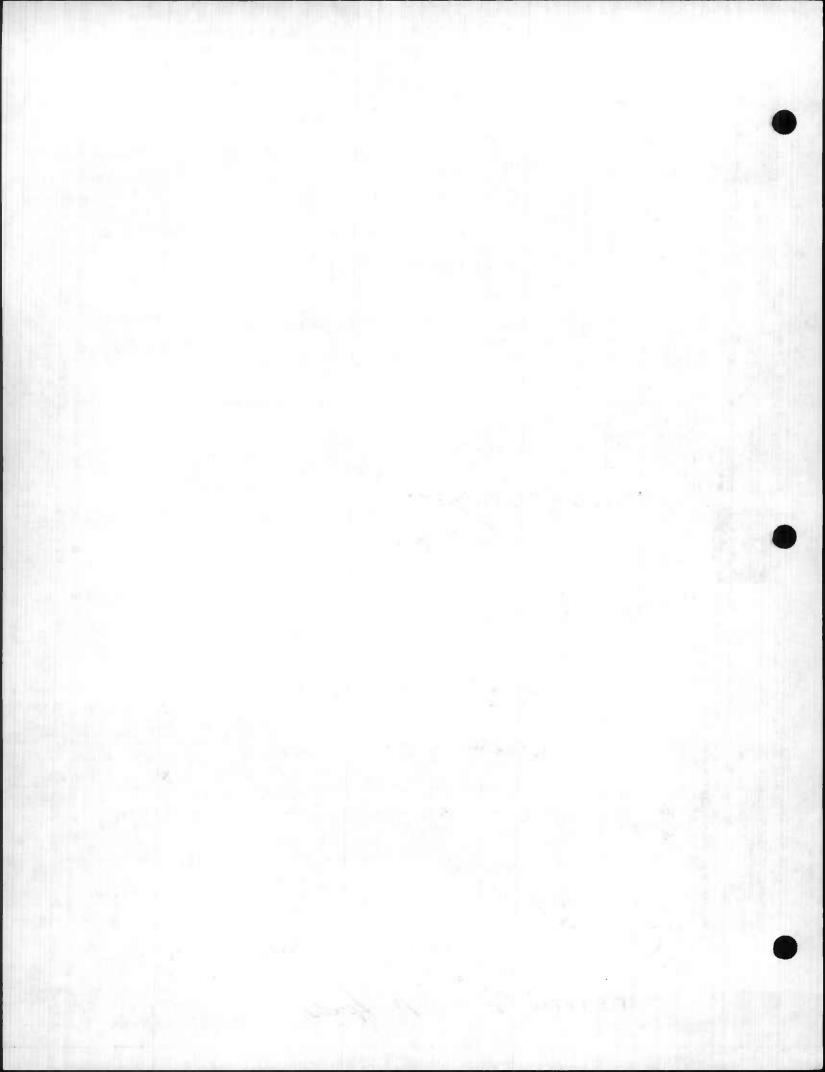
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State of Maryland / Department of Health and Mental Hydiene 100 000 200

	1. Decedent's Nema (First,	Middle, Last)			301	tificate of	50417	2. Data of Dea		3. Time of De	eath
ysician	MARTHA	ELIZABE	ETH	WHITE				Month Februar	Day	Year	:00p
ledical aminer	4a Facility Nama (If not int WICOMICO N						tb. City, Town, or L Salisbur	ocation of Death	4c. County		.000
eral ctor	5. Social Security Number 212-16-7712		2 K F	. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day FEB 20	Year) ,1909	9. Birthplace (State or F Country) MARYLAND	Foreign
	10a. State 10b. 0	ent County		10c. City,	Town or Loc	ation				10d. Inside City	Limits
tor	MARYLAND W	ICOMICO			SAL	ISBURY				1 ☐ Yes 2	No
Director	10e. Street and Number					10f. Zip Code		1	0g. Citizen of V		
	900 BOOTH S'					21801			U.S.A		
by Funeral	11. Marital Status 1 Never Married 2[3] Widowed 4 Dh		Armed Force 1 Yes 2 If Yes, Give Year or Date	ent Ever in U,S. es? No es:	13. W	Yes Decedent of H Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Decify Yes or No- Pican, etc.)	Specify	e - American Indien, ck, White, etc.	
Completed	(Specify only Elementary/Secondary (cedent's Educat highest grade c	ion ompleted) College (1-4		(Give k		ation during most of world)	king		usiness/Industry	
00	17. Father's Name (First, A	fiddle, Last)			SECR	RETARY	18. Mother's Nam	e (First, Middle,		ESTATE	
To Be	GEORGE W.	GLADDEN	1				HARRIET		PARKS		
-	19a, Informant's Name/Re				19b. Mailing	g Addrass (Street	and Number or Ru	ral Route Number	r, City or Town,	State, Zip Code) 326	05
	JOHN W. WHI		Į .				2ND TERR			LE, FLORIDA	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot	ation 3 Rem	novel from St	cen cen	netery, crem	ition (Neme of latory or other pleam MEMORIAL		/10/00	SALISBUI	City or Town, Stata	
1	21. September of Funeral Service Licensee 22. Name and Address of Fecility 705 E. MAI										
28	15. Ke	It t	hom	WE	50 BOI	UNDS FUN	ERAL HOME			URY, MD 2180)4
edical Examiner	Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a b c	End		a consequence a	sence of):	nilo L	Dem	entis	onset and Dec	7
Physician/Med	Part II. Other significant co	d	outing to deat	th but not result	ing in the un	derlying cause giv	ren in Pert I.	23b. Did to	obacco use co	ntribute to the cause of	death?
by Phy	Cereb	rova	peu	lar	D	ica	ee i	1 D Y	es 2 No	3 Probably 4 Un	nknown
Completed	Organ	ie!	Bra	in o	yn	deon	el	24a, Was a perfor	in eutopsy med?	24b. Were eutopsy find aveilable prior to completion of cau of deeth?	
	25. Was case referred to m	os ele	rote	i Ca	edio	vanue	Deces.	th (Check only or		1 ☐ Yes 2 No	0
ToB	examiner? 1 Yes 257No		pital: 1 🗆 Inp	patient 2 E	R/Outpatient	3 DOA Oth	or .	ome 5 Resid		er (Specify)	
Certification:	2 Accident	nvestigation	28a. Data of (Month,	77	8b. Time of Injury		y at k? Yes 2 □ No	28d. Describe h			
Certifi	4 Homicide	detarmined	28e. Place of building	f Injury - At hom i, etc. (Specify)	a, farm, stre	et, factory, office		28f. Location (S City or Tow		er or Rural Routa Numbe	H,
edicai	29e. Certifier 1 1 1 Ce (Check only 2 1 Me one)	rtifying Physici cdical Examiner	an: To the be On the basi and menna	is of examinetio	edge, death n end/or inv	occurred at the tirestigation, in my o	ne, data and place, pinion, death occur	, and due to the c rred at the tima, d	ause(s) and ma lata and place,	annar as stated. and due to the cause(s)	
Σ	29b. Signature and title of o	cortifier	D.		1	29c. Licens			29d. Date signe	d (Month, Day, Year)	
	30. Name and address of p	erson who comp	Selle bleted cause	of death (Item 2	(Type, F		29505		2-14	1-2000	
"/											
3	Gregorio Be 31. Date filed (Month, Day,			hinabe pister's Signetu		rive Sal	isbury M	D 21801			
	30. Name and address of p	erson who comp	pleted cause	of death (Item 2	(Type, P	Print)			1		



			State of Ma	ryland /	Departme Certifica			nd Mental I	Hygiene Reg. No.	0 0983	3
	Physician	Decedent's Name (First, Middle, Last, RONALD	LEVIN		WILLEY		317	2. Date of Month	Dey	Year 2000 153	
SV.	/Medical Examiner	4a Facility Name (If not institution, give			MIDDE	4	b. City, Town	n, or Location of D			
		PENINSULA REGIO	NAL MEDIC	AL CEN	TER		SALI	SBURY	WIC	OMICO	
	Funeral	Social Security Number 6. Security Number		(In yrs. last b	irthday) If Und Month	der 1 Yeer	If Under 24 Hours	Hrs. 8. Dete of	Birth Day, Year)	9. Birthplace (State of Country)	Foreign
	Director	216-38-9769	M 2□ F	58	Yrs.	la Caya	riouis	Janua	ry 30,1942	Maryland	
1		Usuat Residence of Decedent 10a. State 10b. County		10c City Toy	wn or Location					10d. Inside Cit	ed imite
the Mandand	of sho	Maryland Wicomic			itland					1 Yas	
1	or 28a-f be notified Director	10e. Street and Number	.0	rru.		Zio Code			10g. Citizen of	What Country?	
-	The state	211 W. Main St.				2182	26		USA		
-	r hame 234 siner must Furneral		12. Wes Decedent E	ever in U,S.	13. Was De			n? (Specify Yes or Puerto Rican, etc.		ce - American Indian,	
1215-0020	returel; or items 23s or 25s-t show dical Examiner must be notified at eted by Funeral Director	1 🔀 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:		1	pecify Cubs		Puerto Rican, etc.	Specifi	ck, White, etc. y: White	
21215-0020	10 Del	15. Decedent's Edu	cation		a. Decedent's U				16b. Kind of B	usiness/industry	
215	ypere. No than 'natural, It the Medical. Completed	(Specify only highest grade Elementery/Secondary (0-12)		4)	(Give kind of life. DO NOT	work done of use retired	during most o	of working			
CA A	of the	12	2	"	CIA Age	nt			Inte	lligence	
and 2	188 8	17. Father's Name (First, Middle, Last)					18. Mother's	s Neme (First, Mic	Idle, Maiden Surnar	ne)	
aryla	marked marked	Levin W. Willey					Anna	a Margar	et Smith		
- 0	626	19a, Informent's Name/Relationship (Ty		19					ımber, City or Town,	State, Zip Code)	
_ 2	Mar 27	Levin W. Willey/Fa	ther	less mi			Fruit	land, MD			
timore,	2 = 2	20a. Method of Disposition 1X Burial 2 Cremetion 3 R	emovel from State	cemete	of Disposition (*) ary, crematory of	r other plac		Dete		- City or Town, Stete	
1	dury	4 Donation 5 Other (Specify)	, .	Spring	ghill Mem			2/18/0	о неот	ron, MD	
Ba	Bany in	21. Signature of Fineral Service License	ho Oh	ms	Hollo	oway I			rofession sbury, MD	al Associat	ion
		23a Party Enter the disease, or compliance, or heart failure. List only or	cations that caused ne cause on each in	the death. Do	not enter the m	ode of dyin	g, such es ca	ardiac or respireto	ry errest,	Approximete Intervel Betw	
	hysician			hen						Onset end D	eeth
	/Medical xaminer	Immediate Cause (Finat disease or condition resulting in death)		XH	UD					2	
		resulting in death)		Due to (or as a	consequence	of):					
3	nei n).								
_ 6	n and tal-transit Examiner	Sequentially list conditions, if any, leading to immediate	(Due to (or as a	consequence	of):					
Box 68760,	attending physician and for usa as the bunal-transit clan/Medical Examir	cause. Enter Underlying Cause (Disease or injury that initiated events		No. 40 (22 22 2		0.				1	-
68	phy strain	resulting in death) Last		Jue to (or as e	consequence o	11):					
Box	use u		l								
n :	• D =	Part II. Other significant conditions con	tributing to death bu	t not resulting	in the underlying	o cause giv	en in Pert I.	23b.	Did tobacco use co	entribute to the cause o	f death?
Records, P.O.	igned by the a be detached f								I Yaa 2 No	3 Probably 4 U	Jnknown
	be d be d		1.0								
ord	ted touid	Was the same of th	bertibige	Antca					Vas an autopsy erformed?	24b. Were autopsy ti evailable prior to	
9	nple		H KY S							completion of ca	iuse
	Page Page Con							1	☐ Yes 2X No	1 Yes 2	No
of Vital Records,	ector. Be	25. Was case referred to medical examiner?	loenitel:			Out		d Death (Check o	nly one)		
0 4	this o	125 Yes 2 No	lospital:				4LI Nurs		lesidence 6 □Ott		
2	After	Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 280.	Time of Injury	28c. Injury	γατ k? Yes 2∐No		ibe how injury occur	Ted	
ISI Tan	death y the	2 Accident investigation 3 Suicide 6 Could not be	28e. Plece of Inju	ry - At home f			165 2010		on (Street and Numi	ber or Rurel Route Numl	her
DIVISION	rs after death. al Director: After this certificate has be lied in by the funeral director, page 2 should be be certification: To Be Comple	4 ☐ Homicide determined	building, etc.	(Specify)	eiiii, street, rect	ory, onice		City of	Town, State)	oor or ridra riddia ridhii	201,
tosoita	within 24 hours after de To the Funeral Direct completely filled in by the Medical Certific	29a. Certifier 1 ☐ Certifying Phys (Check only 2 Medical Examir	er: On the basis of	examinetion er	e, death occurre	ed at the tin	ne, date end pinion, death	place, and due to occurred et the ti	the cause(s) and m	anner es stated. and due to the cause(s)	
-	thin 2 mplet	one)	and manner stel	ed.		29c. License					
100	8 4 8	29b. Signature and title of commine	10	MF					2. 15 (od (Month, Day, Year)	
	A 70 1			1 1 1		H	049	,	4/15/	<u> </u>	
		30. Name and address of person who co Christopher Snyde	-			Rd.,	Salis	bury, MD			
	State Registrar	31. Date filed (Month Day, Year) 20	32. Registra	r's Signature	B. x	pack	2				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Yası **Physician** Christine Elizabeth White 2000 9:45 PM March /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis ElderCare -The Pines Talbot If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 M 2 F Hours Director 90 Feb. 14, 1910 Virginia 213-16-7448 Usual Rasidence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location t0d. Inside City Limits 28a-f show must be notified at WYes 2 No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Nerns 23a Funeral 21601 death Dutchman's Lane IISA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Race - Amarican Indian. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If Nem 27 Ia marked other than "natural", or Nem any Injury or other traumatic event, the second of the page 1. Black, Whita, etc. 1 Never Married 2 Married Christine White Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Crab Picker Seafood 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) White Joseph Eva Frentress 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 115 Corner Street, Michaels, Maryland 21663 Lorenzo White, sister-in-law 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Deta 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Othar (Specify) 3/9/00 St.Michaels, Maryland Charles Thomas Cem. 21. Signeture of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Cause (Finel diseasa or condition resulting in death) 100 Examiner Due to (or as a con equence of) Examiner physician and the burial-transit The law requires that the death certificate be assocuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760, 8 amic an Physician/Medicai e ut to (or as a consequence of) P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown signed t Records, Ą 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to completion of ceusa of death? Completed page 2 2 No 1 Tyas 1 ☐ Yas 2 ☐ No certificata Division of Vital Attending Physician: 25. Was case rafarred to medical axaminer? Be 26. Pleca of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 4NO Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred An Hospital or Atten-A 24 hours after death. An Director: After An the fu After 1 Netural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direc completely filled in b Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to tha ceuse(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. To the Within 2 29b. Signature and titla of certified 29c. Licensa number 29d. Data signed (Month, Dey, Year) -00 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) MD ASTON MD 21601 SANCHES

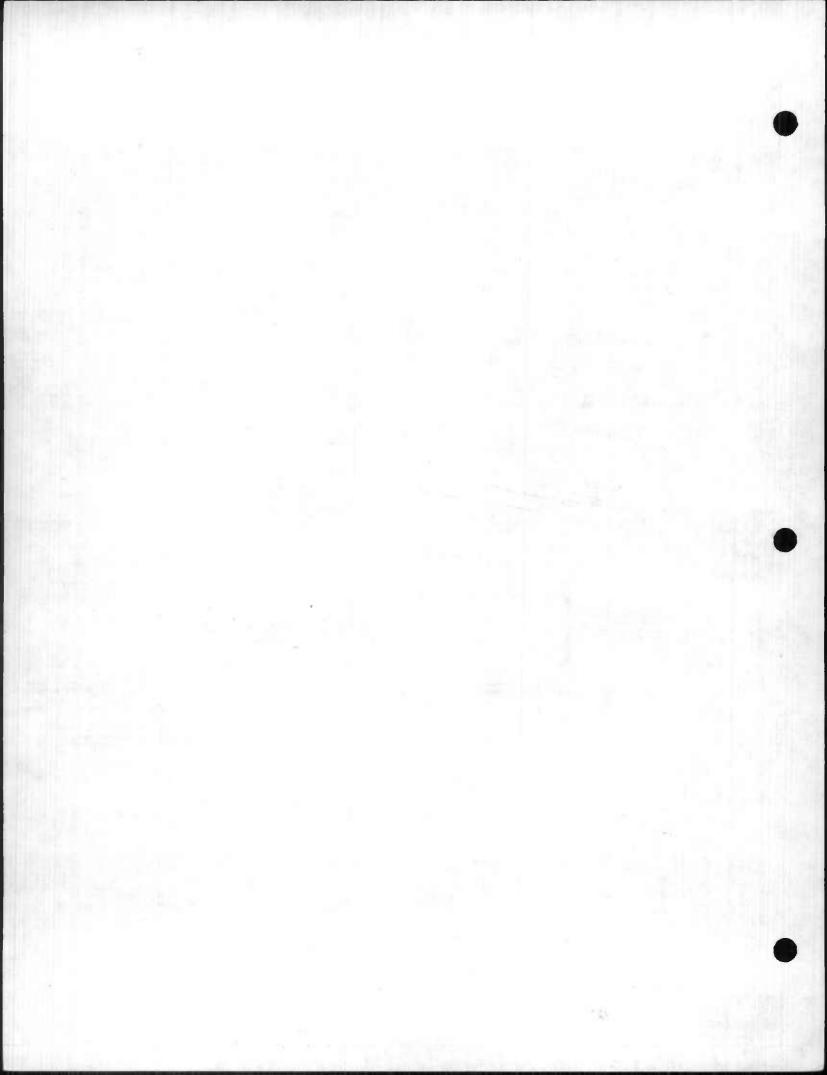
State Registrar

31. Data filed (Month, Day, Year)

MAR O

DHMH 16 Rev 6/95

32. Registrar's Signatura



State of Maryland / Department of Health a Certificate of Death

22. Nama and Address of Fecility

3. Time of Death

2:31 P.M.

10d. Inside City Limits 1 ☐ Yes 2 XNo

WHITE

nd Mental Hygiene	0	0	0	9	8	3	5
Peg No.							-

•		Physic /Med Exami	ical
		unera irector	
0	ifter death with the Meryland	r Rems 23a or 28a-f show niner must be notified at	Funeral Director

r than "natural", or items the Medical Exemples ma

permit. Peges 1 and 2 should be filed within 7; Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medis page.

þ

Completed

Be

filed within 72 hours after

Baltimore, Maryland 21215-0020

1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month HARVEY WATTERSON WALLENDER, III March 02, 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 MM 2□ F Months 464-62-9009 JAN. 7,1943 TEXAS Usual Residence of Decedent 10a Stata 10b County 10c. City. Town or Location TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10667 WYETOWN FARM ROAD 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indian, Black, White, etc. 1 X Yas 2 No If Yes, Give Year or Dates 966-1968 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 MANAGEMENT CONSULTANT TECHNOLOGY TRANSFER 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) HARVEY W. WALLENDER, JR. ANNIE LAURIE KIRKPATRICK 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 799, EASTON, MD 21601 FAY JEAN HOOKER-WALLENDER/ WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OXFORD CEMETERY 3-11-00 OXFORD, MD

Physician /Medical Examiner

physician the buria

USB

been signed by the a should be detached

After this

death.

24 hours after deat Funeral Director:

within 2 To the

Hospital

filled in by

completely

The law requires that the death certificate be axecuted

P.O. Box 68760.

Records.

Division of Vital or Attanding Physician: Examiner

Physician/Medical

à

Completed

Be

Certification: To

Medical

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disaasa or condition resulting in death)

21. Signature of Funeral Service Licenses

Multisystem Organ Failure Due to (or as a consequence of):

Sepsis

Dua to (or as a consequence of):

Traumatic Shock

Due to (or as a consequence of):

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

Multiple Injuries

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

3 Probably 4 Unknown

24a. Was an autopsy performed? Approval

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

2 No 1 Tyes

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 XYes 2 No 27. Manner of Death

1 Natural

2 X Accident

3 Suicide

29a. Certifier

4 Homicide

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 11-21-1999 6 Could not be determined

28b. Time of Injury 5:15 P 28c. Injury at Work? 1 Tes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Head-on motor Subject driver: Yehicle acci-

6 Could not be determined

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Ocean Gateway near Sportsmans Neck Road, Queens-town, Mary Land.

38 Certifying Physician: To the best of my knowledge, death to the cause of the cause (s) and manner as stated.

39 Martical Examples: On the best of my knowledge, the properties of my original death popularity and due to the cause (s) and manner as stated.

(Check only one) Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific

-arnell

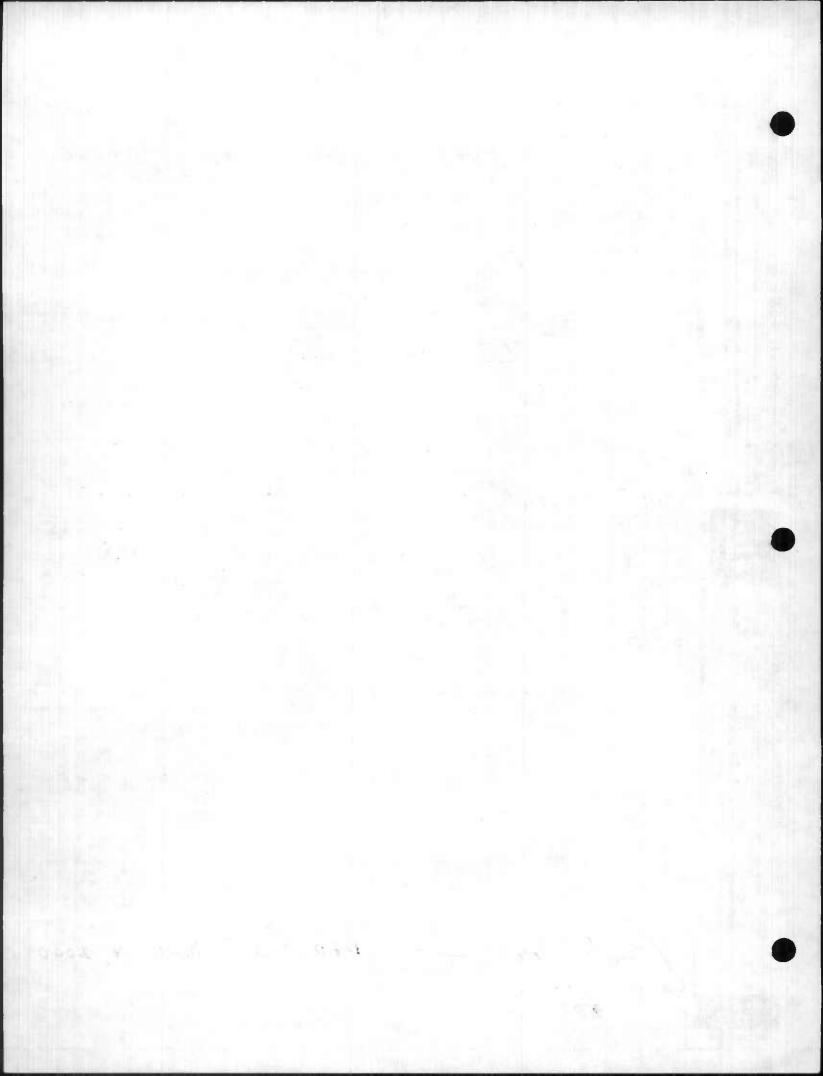
29c. License number D4038 29d. Data signed (Month, Day, Year) 2000

completed cause of death (Item 23a) (Type, Print)

a

22 S. Greene Street, Baltimore, Maryland 21201

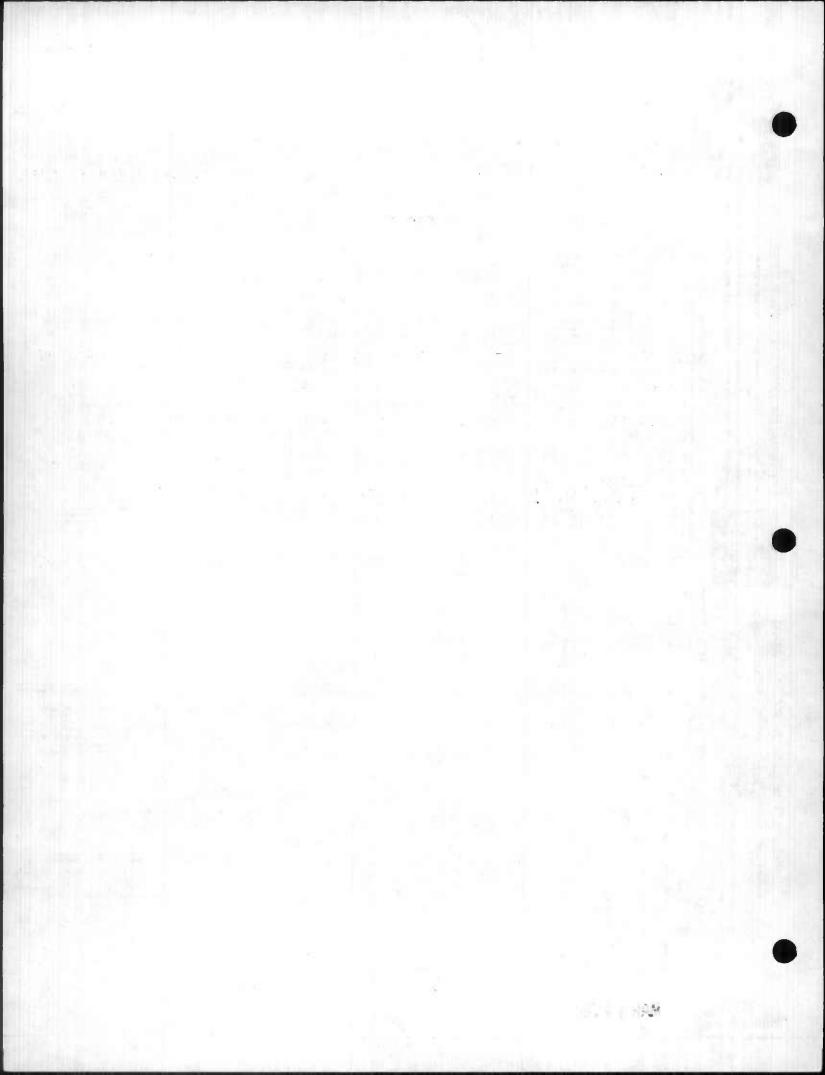
State Registrar 00 32. Registrar Signature 2000



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

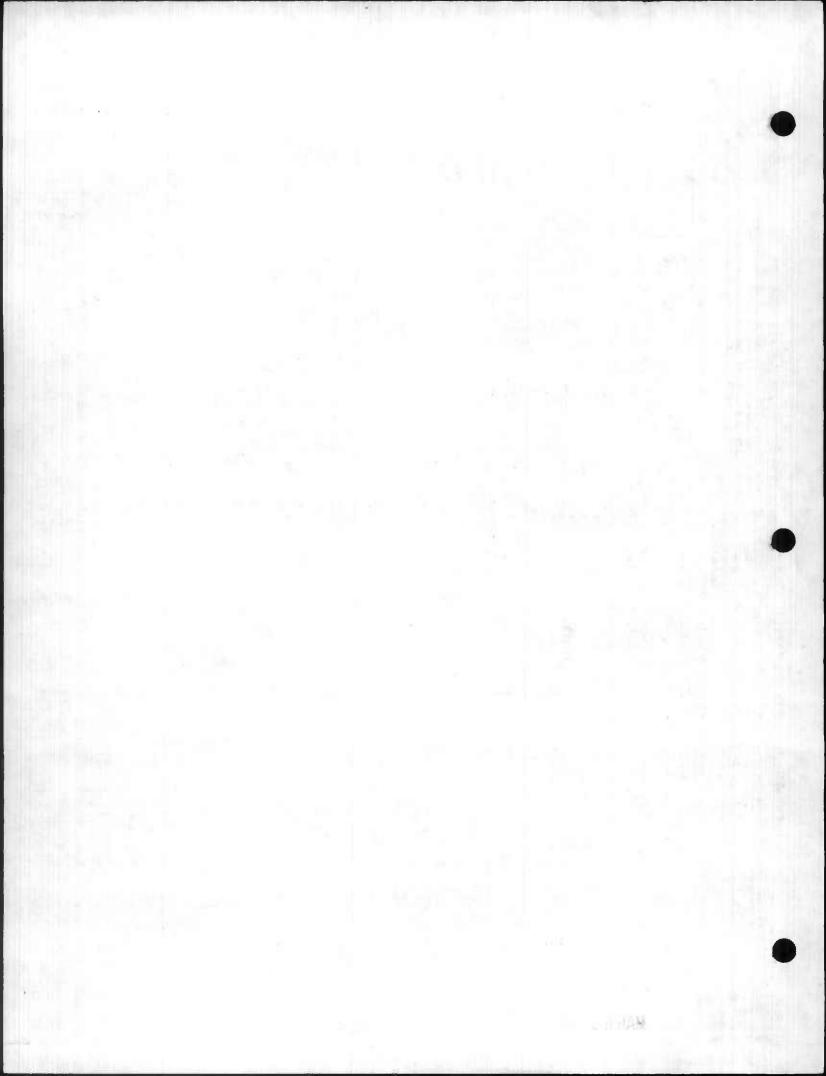
State of Maryland / Department of Health and Mental Hygiene [] [] 9836

				Certifica	ate of	Death	,	leg. No.		, , , , ,
Dhualaian	1. Decedent's Nama (First, Middla,	Last)					2. Data of Dea Month	th Day	Year	3. Time of Death
Physician /Medical	Margaretta Mar	y Wilson					March		00	1:45A.M
Examiner	4a Facility Nama (If not Institution, g	riva street and number)			4	b. City, Town,	or Location of Death			
	111 Cara Cove	e Rd.			N	orth E		Ceci	1	
Funeral Director	190-16-8231	Sex 7. Ag	e (In yrs. last b	Yrs. If Und Month	der 1 Year is Days	If Under 24 H Hours M		Year)	Country	ce (State or Foreign y) Sylvania
	Usual Rasidance of Decedent 10a. Stata 10b. County		100 City Tox	wn or Location					100	d, Inside City Limits
aho Mal									100	N⊟Yes 2 No
be notified Director	Cecii		Nort	h East						11.11
	10e. Street and Number	e Rd.		101.	Zip Code 2190	1		U.S.A		y?
Examiner must	11. Marital Status 1 Nevar Married 2 Married 3 KWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yas 953 If Yas, Give Year or Dates:		If Yes, s	pedent of H pecify Cubi 2 No	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Blac	e - American ck, White, et White	IC.
4, the Medical.	15. Decedent's		16	Decedent's U	sual Occup	ation during most of v	undring	16b. Kind of Bi	usiness/Indu	stry
Mes uple	(Specify only highest g	College (1-4or	5+)	lifa. DO NOT	use retired)	working .			
the mo	12			ook Ke	eper			Air li	ine –	Boeing
avent Be (17. Fathar's Nama (First, Middla, La	st)				18. Mother's N	lame (First, Middle,	Maiden Suman	10)	
To	Arthur DeHar	t				Alice	Heald			
5	19a, Informant's Name/Ralationship	(Type, Print)	19	b. Mailing Addre	ss (Street	and Number or	Rural Routa Numbe	r, City or Town,	State, Zip C	Code)
	Doris Eiching	er (Daught	er) 11	2 Unio	n Va	lley I	Rd. Elkt	on, Md.	219	21
offe	20a. Method of Disposition		20b. Place	of Disposition (N	lame of	m)	Data	20c. Location -	City or Tow	n, Stata
7 04	1 Donation 5 Other (Special 2)				-		3/15/00	Picin	a Sin	h Md
100	21. Signatura of Bureral Service Lice		Rose	Bank (ss of Facility	3/13/00	KISII	ig sui	n,na.
once	THE WAY						Funeral	Home		
	MAIX	u		250 F	C. Ma	in St.	. Elkton	. Md.	2192	1
	23a. Part1, Enter tha demisa, or co shock, or haart failure. List on	mplications that caused	the death. Do	not enter the m	ode of dyin	g, such as card	liac or respiratory ar	rest,		Approximata nterval Between
cian										Onset and Death
lical	Immediate Cause (Final disease or condition as Lung Can cey									740,00
niner	resulting in death) Due to (or as a consequence of):							1	Jeurs .	
je l					,					
ounal-transit	Sequentially list conditions	b	Due to for as a	consequence of	n.				1	
EX	Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Causa (Diseasa or Injury		D 10 (01 E3 E	CONTROQUENCE C	.,.				1	
	Causa (Diseasa or Injury that initiated events	c							1	
edicai	rasulting in death) Last		Due to (or as a	consequence o	():				1	
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lan										
perached for use	Part II. Other algnificant conditions	contributing to death b	ut not resulting	in tha underlyin	g cause giv	en in Part I.	23b. Did 1	obacco use co	ntribute to t	the cause of death?
Physician/M							10	res 2000	3 Probe	ably 4 Unknown
2 6							_		T	
Completed				25-			24a. Was perfo	an autopsy med?	avail	e autopsy findings lable prior to pletion of cause eath?
rector, page 2							101	es 2 No	10	Yes 2 No
9. O	25. Was casa rafarred to medicat					26 Place of F	Death (Check only o			
iractor.	axaminar?	Hospital:			Oth	or:				
funeral dir ion: To	1 Yas 20 No 27. Mannar of Death 1 Natural 5 Pending	28a. Date of Inju	ent 2 ER/O	Time of Injury	28c. Injur Wor	y at k?	Home 5/2 Resid			
he fune	2 ☐ Accidant invastigat			М	10	Yes 2 □ No				
Certification:	3 Suicide 6 Could not 4 Homicida detarmine	289. Place of In	ury - At homa, f c. (Specify)	arm, street, fact	ory, office		28f. Location (S City or Tox	treet and Numb n, State)	per or Rural i	Route Number,
completely filled in by the	29a. Certifier 1 Certifying I (Check only one) 2 Medical Exp	Physician: To the best aminer: On the basis o and manner st	examination a	e, death occum nd/or investigati	ed at the tin	ne, data and pla pinion, death oc	ice, and due to the coursed at the time,	ause(s) and mi	anner as star and due to t	ted. the cause(s)
To the Funeral Director: completely filled in by the Medical Certifical	29b. Signature and title of certifier	and manner st	a.00.		29c. Licens	a number	1	29d. Data signe	d (Month D	lev Yearl
8	A Continue of Continue	1			Julian Company	- 110111001				**
	1 / ta	rkes, m	9		Di	531	4	Murch	14.	2000
	30. Name and addrass of person wh	o completed cause of c	leath (Item 23a)	(Type, Print)			1		11	
	H Furkas	MD Us	1/1/	o The	rn C	Le says	who the	pice, 15	1kto	ar, no
State*	31. Date filed (Month, Pay Year)	32. Registr	ar's Signatura	1			1-11			
Registrar	MAK 1 4 ZUUU	Denera	19.	Some	61					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Physician Month Veer SAMES MARCH 2050 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPi Ceci 5. Social Security Number If Under 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) **Funeral** Months Daya Hours 1X M 20 F Yrs. Director 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Vas 2 No Director New CASTIE DE/AWARC WILMINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 11. Marital Status Black, Whita, atc. 1 Nyes 2 No If Yes, Giva 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black by If Yes, Give Yaar or Datas: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: If Itam 27 is marked other than eny Injury or other traument. Elementary/Secondary (0-12) Collega (1-4or 5+) JANI FORIAL NUYSING Home 17. Father's Nama (First, Middle, Last) 18 Mother's Nama (First Middle Maiden Surname) Be JAmes Wheelex BIVIRA Sm 0 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) CINdy Wheeler 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 3 1 Burial 2 Cremation 3 Removal from State 18/2000 CemeTery Donation 5 Other (Spe of Funaral Service 22. Name and Addrass of Facility N. GRAY Ave.
Approximate interval Between Onset and Death 00467 Cargo FUNEYAL Home caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Sensis Examiner ettending physician and for use as the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Web neumonia Division of Vital Records. P.O. Box 68760 Physician/Medical Dua to (or as a consequance of): years Obstructive Pulmonary Disease Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yas 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler adical (Check only one) 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) 3.7.2000 123322 Herebolen SMD 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) ERBEMMD21921 S. S. SACHDEN MD 118 North St, Suite 3B 32. Registrar's Signature 31. Data filed (Month, Day, Year) State Registrar MAR 0 9 2000



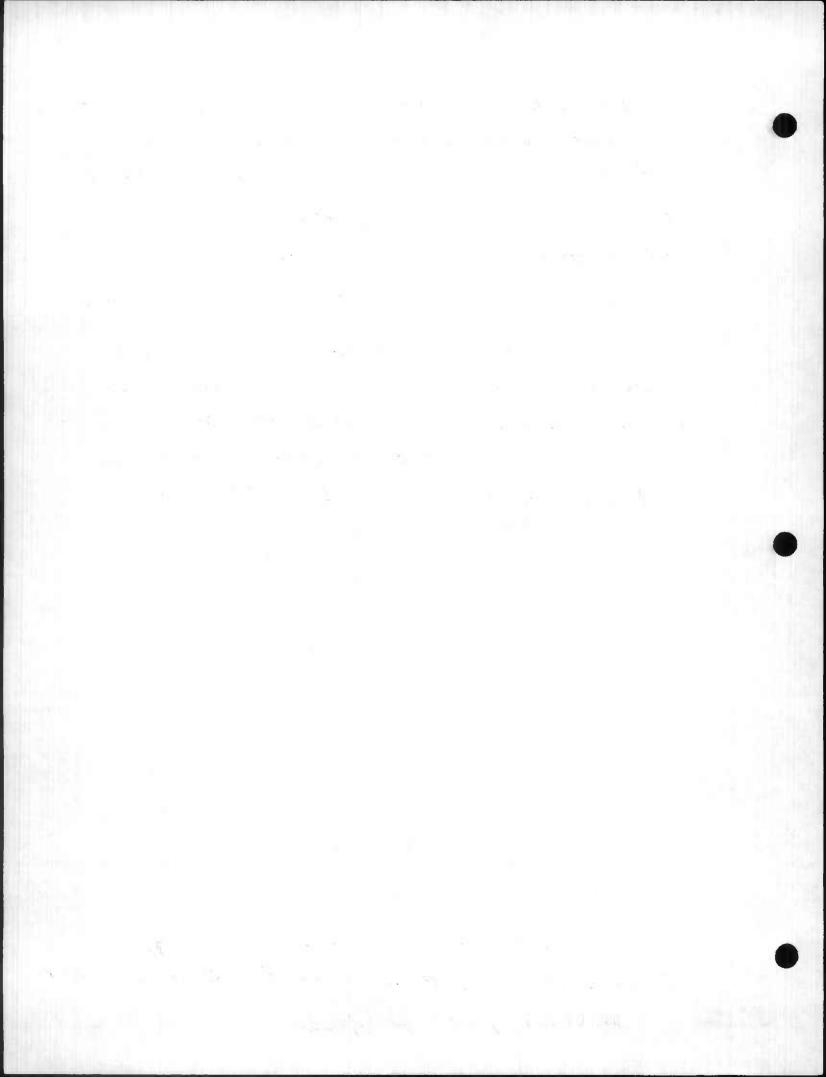
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State of Maryland / Department of Health and Mental Hygiene 0 0 0 9 8 3 8

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t not resulting in the	e underlying cause	given in Part I.		obacco use col	ntribute to the cause of dea			
			24e. Wes perfor	med?	24b. Were eutopsy finding available prior to completion of cause of death?	S		
		an Disease Day	1 D Y		1 ☐ Yes 2 ☑ No			
nt 2 ER/Outpet	atient 3 DOA		ith <i>(Check</i> on <i>ty</i> o		er (Specify)			
Year) 28b. Time injury	e of 28c. in	njury et Vork?	28d. Dascribe h			Ī		
2 Could not be								
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State Registrar

31. Dete filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death W. LSON SR. MARCH

4b. &ty, Town, or Location of Deeth 5, 2000 4c. County of Death WARNER 4a. Facility Neme (If not institution, give street end number) Washington Adventist Hospital Takoma Park 7. Age (In yrs. lest birthdey) 1**∑** M 2□ F 72 Yrs. 570-24-6741 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's New Carrollton 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6113 Westbrook Dr. 20784 United States 12. Was Decedenf Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 4 U.S. Postal Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Warner Wilson Cora L. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6113 Westbrook Dr. New Carrollton, Md. Warner H. Wilson, Jr. 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery 3/11/00 Washington, D.C. 22. Name and Address of Facility
Alexander S. PopeFuneral Homes 21. Signature of Funeral Service Licensel 23a. Part 1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10-12 months Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ Vio 1 ☐ Yes 2 ☐ No

Physician/Medical Examiner be executed P.O. Box 68760, the Records, Completed by Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; Be Certification:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6

"natural", or items 23a

Hygiene.

Pages 1 and 2 should be filed an anti-if item 27 is marked other

or other trac

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Examiner must be notified at

Director

Funeral

by

Completed the Medical

> Hypertension Diabetis Mallitus

> > 37 Registrar's Signature

examiner?				26. Place of De	setn (Check only one)
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Death 1 Neturei 5 Pending 2 Accident investigation		28b. Time of injury	М	28c. Injury at Work?	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At building, etc. (Spec	home, farm, stree cify)	t, fact	ory, office	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)	2 Medical Examiner: On the	the best of my knowledge, death or e basis of examination and/or Inves nenner stated.	ccurred at the time, date and place, and due to the time time, death occurred at the time.	he ceuse(s) and manner es stated. ne, date and plece, end due to the cause(s)
29b. Signature apt	Acy 6 MD	Mending	29c. License number D 42580	29d. Date signed (<i>Month</i> , <i>Dey</i> , <i>Yeer</i>) 3-6-20-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YARMIT Aujta, mb 31. Date filed (Month, Dey, Year) 32 Rec

MAR 0 8 2000

5632 ANNApolis Rd. #13, Blodershuy, ms. 20110

State Registrar

Medical

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year Carol F. Wanner March 5, 2000 11:45 A.M 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 6005 Maiden Lane Bethesda Montgomery

If Under 1 Year

10f. Zip Code

Days

20817

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

7. Age (In yrs. last birthday)

Yes

10c. City, Town or Location

Bethesda

1□M 2QF

12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:

College (1-4or 5+)

If Under 24 Hrs.

Hours

Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No

GOODVIEW ST BETHESOA MO 20817

🖎 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(a) end menner steted.

29c. License number

8. Dete of Birth (Month, Dey, Year) June 13, 1913 Washington DC

10g. Citizen of What Country?

Specify:

United States

16b. Kind of Business/Industry Library of Congress

Rece - American Indian, Bleck, White, etc.

White

Approximete Interval Between Onset and Death

completion of cause of death?

1 ☐ Yes 2 ☐ No

Location (Street end Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

Birthplace (State or Foreign Country)

t0d. Inside City Limits

1 Yes 2 No

Director or 28s-f show Items 23a 8 Baltimore, Maryland 21215-0020 'natural'. 2 should be 1 and Mental 1 is marked

Physician

/Medical

Examiner

Funeral

5. Social Security Number

10e. Street and Number

6005 Maiden Lane

1 Never Merried 2 ☐ Merried

3 Widowed 4 Divorced

Elementery/Secondary (0-12)

10a. Stete

MD

Director

Funeral

Completed

Be

2

216 44 2758 Usual Residence of Decedent

10b. County

P.G.

15. Decedent's Education (Specify only highest grade completed)

5 Panding

KICHERO CIMPLISKIN

2 Accident

3 Sulcide

29e. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certilier

31. Dete filed (Month, Dey, Year)
MAR 0 7 2000

investigation

chr.

MO.

32. Pegistrer's Signeture

30. Name and eddress of parson who completed causa of death (Item 23a) (Type, Print)

6 Could not be determined

permit. Pages 1 and 2 should be Department of Health and Mental Important: if them 27 is merited 1 any Injury or other traumatic eve and hijery or other traumatic eve

Physician Allegrean Examiner Examiner be executed ician and burial-trans Box 68760. Physician/Medical the PO signed by Records. by Completed of Vital Attending Physician: Be Certification: To this Division After death. after death Director: 6 hours 24 hours Medicai To the Hosp within 24 ho To the Fune completely fi

U.S. Federal Government 12 6 Librarian 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Elsie Herrle Charles R. Wanner 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20896 19a. Informant's Neme/Reletionship (Type, Print) Colin Herrle , Jr. (COUSIN) Box 350 11119 Kenilworth Ave, Garrett Park, MD 20e. Method of Disposition
1 Burial 2 Cremetion 3 Removel from Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Lee Crematory March 7, 2000 Clinton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility ee Funeral Home, Inc 6633 Old 21. Signeture of Funeral Service Licen-Alexandria Ferry Road, Clinton, Maryland 20735 Party Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Ceuse (Final disease or condition resulting in deeth) HEART FAILURE CONGESTIVE NEART GAILURE Due to (or as e consequence of): HYPERTERSON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to 24a. Wes en autopsy 2No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home STAResidence 6 Other (Specify) 1 Yes ZX No 28a. Dete of Injury (Month, Dey Year) 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of

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10

State Registrar

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

6204

1908 8 5000 Green 100 1000

Ed the part of the

1. Decedent's Neme (First, Middle, Last)							2. Date of Death 3. Time of					Death	
Florence Williams								March	Day 2	OOO	9:10	DM	
4a Facility Name (If not			mber)			4	4b. City, Town, or I				3.10	P	
Howard County General Hospital							Columbia	bia Howard					
5. Social Security Number 6. Sex 1 ☐ M 270%F						Months Days Hours Min. 8. Dete of Birth (Month, Day, Year)			rth ay, Year)	Birthplace (State or Foreign Country)			
179-14-5916		77 Yrs.					April 18	18 1922 MA					
Usuat Residence of Dec	b. County		10c. Ci	ity, Town or Loc	cation	_				10	Od. Inside Ci	tv Limits	
MD H	loward								1 🗆 Yes				
MD H	1 00	Columbia 10f. Zip Code					10g. Citizen of What Country?						
5014 Ten		21044					USA						
11. Meritat Status		12. Was Dece	as Decedent Ever in U.S. 13. Wes Decedent			dent of H	lispanic Origin? (S	or No- 14. Race - American Indie C.) Black, White, atc.					
1 Never Married 3 XWidowed 4	2 (MNo /a ates:	XNo 1 ☐ Yas 2 X No			uban, Mexican, Puèrto Rican, etc.) Io Specify:		Specity: white						
15.	Decedent's Educ	cation		16a. Deced	ent's Use	el Occup	etion	tina	16b. Kind of Br	usinass/Ind	ustry		
Elementary/Secondar	nly highest grade ry (0-12)	College (1	-4or 5+)	lifa. C	OO NOT	ise retired	etion during most of word)	Kiriy					
12				Homema	ker				Own Ho				
	17. Father's Name (First, Middle, Last)					18. Mothar's Name (10)			
	Robert Murray							a Halas		Orate T	On dai		
19a. Informent's Name/ Steve Will							and Number of Runcle, El						
20a. Method of Disposit		9011	20b. 1	Place of Dispos				Date	20c. Location -				
1 28 Burial 2 □ Cr	remation 3 DR	emovet from	21616		-								
4 ☐ Donation 5 ☐ 21. Signeture of Funera		1	St	. John					Ellicot		f	wrice	
1 2 d	alel			St 93	ephe 33 Gi	n D. st A	ss of Facility Ra Lohrman ve. Silv	er Spri	ng, MD 2	0910	on se	rvice	
Immediate Causa (Fina disease or condition resulting in death)	a b	<i>F</i>	Due to (or es a consequ	uance of	:	Stage I	V		6	mont	hs	
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence ot):											
that initiated events resulting in death) Last Pert II. Other significan	l.		Due to (d	or as a consequ	uence of)					1 1 1			
5 . 11 . 611								1 001 011		- 1		4 4 4 4 4	
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause						cause giv					the cause		
Chronic A	nemia, A	Anorme:	ia - Ca	chnaia				1)(Yee 2□No	4 P P 100	any 4	OHAHOWI	
COPD, Osteoporosis								24a. Was an autopsy performed? 24b. Were autopsy find available prior to completion of caus of death?			0		
									Man aMan			No	
25. Was casa referred t	to medicat		O. E. Y				26. Placa of Dea		Yes 2 No	1	Yes 2	140	
examiner?	-	ospitat:	npatient 2	Other					idence 8 Oth	er (Specifi	()		
27. Manner of Death		28a. Date	of tnjury	28b. Time of		28c. Injui Woi		-	how injury occur		,		
1 Disturat 5	Pending investigation	[MONI	th, Day Year)	Injury M		1 Yes 2 No							
27. Manner of Death 1								28t. Location (Street and Number or Rurel Route Number, City or Town, State)					
		er: On the ba					me, data end place pinion, death occu					5)	
29b. Signature and title	of certifier		0		25	c. Licens	se number		29d. Date signe	d (Month, I	Day, Year)		
1 Clou	x m	June	1			03	0573	- 1	3-6-	00			
30. Name and address of	of person who co	mpleted caus	e of death (Ite	m 23a) (Type I			3						
O. cos						0.1	1 . 1	D 040//					
Jon K. Minf	ord 1106	ob Liti	tle Par	uxent 1	KWV	COL	lumbia. M	D 21044					

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Rita Norma Wells 2000 March 1, 3:50p.m. /Medicai 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F 71 579-34-9396 Yrs. Director October 15,1928 Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 No Maryland Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20722 3404 Webster Street U.S.A. Herms 23e Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural', or Specify: White 1 ☐ Yes 2 No Specify: by 3X Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mantel Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, tre Dry Cleaning 12 Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) th and Mantel H Peges 1 and 2 should be Arthur Jerome Divver Wiggington Lilla Fante 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if item 27 is or other trac Mary Ann Cooksey - Daughter 3404 Webster Street, Brentwood, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) George Washington Cemetery 3/6/2000 Adelphi, Maryland 22. Name and Address of Facility Gasch's Funeral Home, 4739 21. Signature of Funeral Service Ligensee Baltimore Avenue, Hyattsville, Maryland 20781 20 23a. Part1. Enter the tilsease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final RESPIRATORY disease or condition resulting in death) Examiner Chronic Obstructive Pulmonary Disease Examiner The law requires that the death certificate be axecuted and-tran-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Physician/Medical tha Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Steroid related Hyperplycemia 1 Yee 2 No 3 Probably 4 Unknown Records, 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this ar daath. rector: After this by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred al or Attending P s after death. I Director: After t Division 5 Pending investigation 1 DNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 22549 March 01,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
G. M.D. N. D. 6510 Kenilworth Ave, Riverdale M.D. 20737 37. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 6 2000 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09843 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ANDERSON WILLINGHAM. JR. March OT 2000 3:35 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6107 Wood Pointe Drive Glenn Dale Prince George's If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 10 M 20 F 65 Yrs. 223-38-0741 New York, N.Y. Director July 16, 1934 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ma 23a or 28a-f ahow must be notified at Maryland Prince George's 1 X Yes 2 No Director Glenn Dale 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? Nema 23a or 6107 Wood Pointe Drive 20769 U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Hygiene. rther than "natural", or Item ant, the Medical Examinar. hours after 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitlmore, Maryland 21215-0020 Black 1 Tyes 2 No. Specify: Specify: p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) Capitol Police Officer Government pernit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: if Itam 27 is marked other th any Injury or other traumatic avant, the 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Anderson Willingham, Sr. Elsie West 19a. Informant'a Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Voncile Willingham/Wife 6107 Wood Pointe Drive, Glenn Dale, MD 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 03707 1 Burial 2 Cremation 3 Removal from Stele Arlington National Ceme. 2000 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21 Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 Ter cen nau 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tartire. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical CARDIOPULMONARY ARREST Examiner Due to (or as a consequence of) Examiner LUNG CANCER physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thal initiated events resulting in death) Last Due to (or as a consequence of): HEART FAILURE Physician/Medical Due to (or as a consequence of): for use as 88 signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 VUnknown p The law requires 24b. Were autopsy lindings available prior to completion of cause of death? ahouid I 24a. Was an autopsy performed? Completed page 2 a 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No certificate Attanding Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛣 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending n 24 hours after death.

• Funeral Director: Al death. 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, streel, lactory, office building, etc. (Specify) 4 Homicide 6 Hospital 29a. Certifier edical 11/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) iner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cx - 9 20d. Dale signed (Month, Day, Year)

0

Registrar

Box 68760

P.O.

Division of Vital Records.

31. Dete liled (Month, Day, Year) MAR 0 6 2000

ess of person who comp

29b. Signature and litle of certifier

Bernard Frazin, M.D., 7525 Greenway Center Drive, #T-3, Greenbelt, MD 32 Registrar's Signature

ed cause of death (ttem 23a) (Type, Print)

DHMH 16 Rev 6/95

29c. License number

0

March 3, 2000

MAR 5 6 2000 journey B. ...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 09844 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 4:10 AM 2 ETTA YOCCA 24 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4699 Snow Hill Rd. Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** 10 M 20 F Months Deys Hours Min Yrs. Director 69 181-26-0332 2/11/1931 Pennsylvania Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itsms 23s or 28s-1 show traumstic event, the Medical Examinar must be notined at 1 Yas 2 No Director Wicomico Salisbury the th 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With Funeral 4699 Snow Hill Road 21804 deeth USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours effernent of Health and Mental Hygiene. 1 Never Married 2 Married 21215-0020 Yes, Give 1 Yes 2 No Specify: by Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Seamstress Clothing Maryland 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Walter Edward Bagley Elizabeth Grace 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Nem 27 is eny Injury or other trau 4699 Snow Hill Rd., Salisbury, MD 21804 (husband) Peter A. Yocca Baitimore, 20b. Plece of Disposition (Nama of cemetary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens 2/28/00 Hebron, MD 21. Signeture of Funeral Service Licenses 22. Neme and Address of Facility Holloway Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that ceused in death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. CFSP MD 21804 Approximate Intervet Between Onset and Death Physician /Medical tmmedieta Cause (Finet disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner The lew requires that the death certificate be axecuted the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Dua to (or as a consequence of): Pug Box 68760, physician Physiclan/Medicai Due to (or es a consequence of): USB 85 1 aigned by the atter P.0. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2500 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? has 1 Yes 2 No. this certificate 1 Yes Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas BNO Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To funeral 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation **■** Natural ne Hospital or Attending n 24 hours after death. The Funeral Director: Aft 2 Accidant 1 TYes 2 No å 6 Could not be 28l. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide

State

completely

within 2 To the 4

Medicai

29e. Certifier

29b. Signali

(Check only one)

me and address of person who completed causa of diam (Itam 23a) (Type, Print)

8 2000

FEB 2

Registrar

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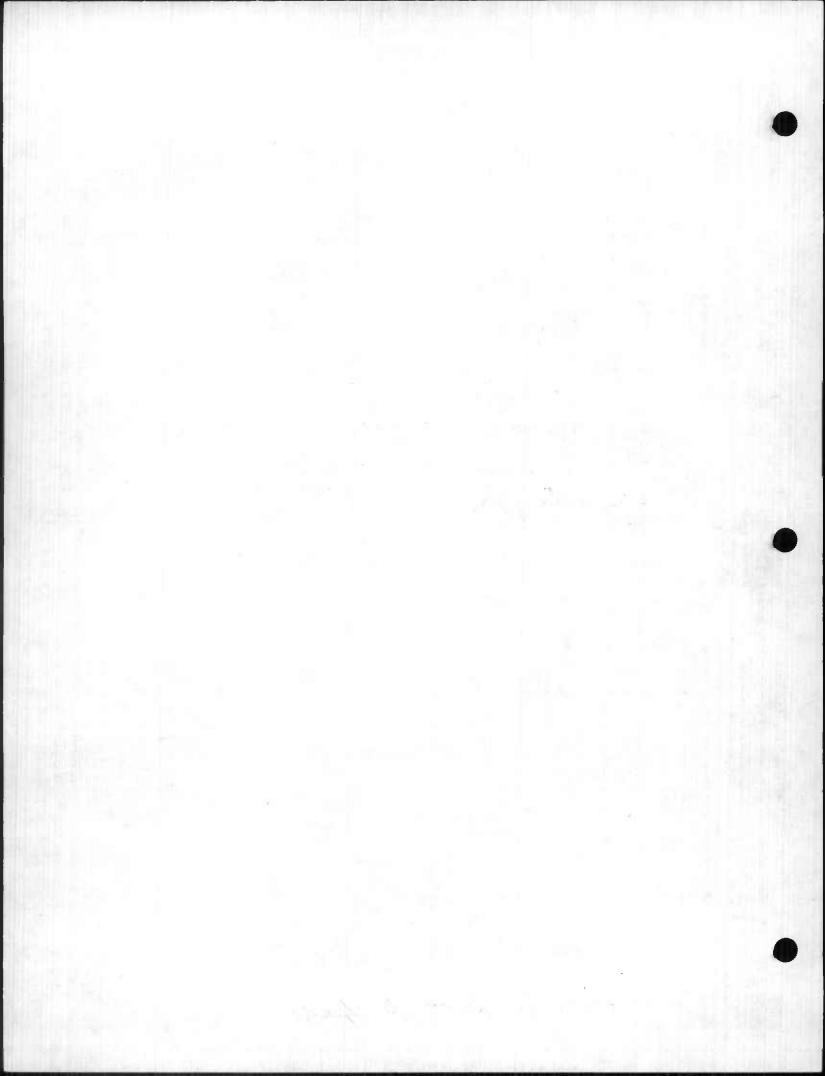
32. Registrata Signature

Certifying Physician: To tha best of my knowledge, daath occurred at the time, data and plece, and dua to the cause(s) and menner as stated.

2 Medical Examiner: On the besis of axamination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

29d. Dete signed (Month, Day, Year)



		St	ate of Maryland		artment of rtificate of		and Me		ene 0) (9845
		1. Decedent'a Name (First, Middle, Last)						2. Dete of Death			3. Time of Death
	hysician	Carol Jean Young						Month March	6 20	Year 000	14:30AM
	'Medical xaminer	4e Fecility Neme (If not Institution, give street	and number)			4b. City, To	wn, or Loc	cation of Death	4c. County	of Death	
1		Prince George's Ho	spital			Cl	hever	1y	Princ	ce Ge	eorge's
	neral ector	5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs. In 57	ast birthday) Yrs.	Months Day		Min	8. Date of Birth (Month, Day,) Dec. 5,	^(ear) 1942	9. Birthp Cour Was	place (State or Foreign htry) h., D.C.
death with the Maryland	Funeral Director	Usual Residence of Decedent 10a. Stete 10b. County Maryland Prince Geor		, Town or Lo		Riverda	ale			1	0d. Inside City Limits 1 1 Yes 2 □ No
it the	Oire	10e. Street and Number			10f. Zip Code	4		100	. Citizen of V	Vhat Cour	ntry?
ath w	9 6	5707 Nicholson St.				0737			Unite		
	eted by Funeral Director		as Decedent Ever in U,5 med Forces? □ Yes 2 ऒ No Yes, Give ear or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🔀 No		gin? (Spec n, Puerto P	city Yes or No- Rican, etc.)		k, White,	ean Indian, etc. .ack
2 hot	es pe		-1-4-4)	16a. Dece	dent's Usual Occi kind of work don DO NOT use retir	upation	t at unadia	16	6b. Kind of Bu	ısinass/în	dustry
thin 7	Med	(Specify only highest grade com Elementary/Secondary (0-12)	pleted) ollege (1-4or 5+)	life.	DO NOT use retir	ed)	LOF WORKIN	ig .			
ed wi	r, re Medical	12th		Cust	omer Ser	1				rivat	e
aryiand ZIZIO-UUZU should be filed within 72 hours after nd Mental Hygiene.	or other traumatic event,	Clarence Fleto					Vi	(First, Middle, Ma vian Fis	sher		
		19a. Informent's Neme/Reletionship (Type, P Sterling Young - Sp		1	ng Address (Stree)7 Nichol				-	2073	
Tand Healt	The contract of	20a. Method of Disposition	20b. PI	ace of Dispo	osition (Name of				oc. Location -		
ages in of in	70	1 Burial 2 Cremation 3 Remov	el from State		Memoria		3/	11/2000	Suit	land.	MD
permit. Pages 1 and 2 Department of Health a	any Injury	21. Signature of Funeral Service Licenses	a. 0 11	,	2. Name and Add	ress of Facilit	y St	ewart Fi	neral	Home	
box 60/00, th certificate be executed Exam Endino physician and	dical	Ceuse (Disease or Injury that Initiated events resulting in death) Last	Pulma Due to (or OUAR Due to (or		Quence of): CAN quenca of):				st,		Approximate Interval Between Onset and Deeth
a death	sici	Pert II. Other significant conditions contribut	ing to deeth but not resu	Iting In the u	underlying cause	given in Part I	l,	23b. Dld tob	acco usa co	ntributs t	o the cause of death?
requires that the	be detact by Phy							1 🗆 Ys:	2 No	3 Pro	bably 4 Unknown
aw requires t	O Q							24a. Was an perform		6/	fere eutopsy findings vaileble prior to emptetion of cause death?
The law	page							1 ☐ Yes	2 No	1	☐ Yes 2☐ No
To the Hospital or Attending Physician: T within 24 hours after death. To the Funeral Director: After this certifical	al director.	25. Wes case referred to medical exeminer? 1 Yes 2 No Hospit	al: 1 Inpatient 2 124 a. Date of Injury (Month, Day Year) e. Plece of Injury - At ho building, etc. (Specify	ER/Outpatie 28b. Time of Injury	28c. In W	Other: 4 Nu jury at ork? Yes 2	ursing Hon 2 No	Check only one ne 5 Resider 28d. Describe how 28f. Location (Str. City or Town,	nca 6 Oth	red	ify) al Route Number,
Hospital or 4 hours after Puneral Dir	pletely filled in		: To the best of my know	vledge, deet	h occurred at the	time, dete an	id place, a	ind due to the cal	use(s) end me	enner as s	stated. to the ceuse(s)
To the	comple		u _ W.L)	-	8680	2	29 W	d. Date signe	d (Month,	Day, Year)
(4	<i>f)</i>	30. Name and address of person who completed the state of	and and a second	23a) (Type,	Print)			Je #23	o Re	xku	ille
Re	State egistrar	31. Date filed (Month, Day, Year) MAR 0 9 2000	32 Registrer's Signet	J.	Spark						

State of Maryland / Department of Health and Mental Hygiene UU

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** 2000 Robert Lee Zang 4:00am /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours 77 047-22-4967 Yrs. May 5, Director MD Usual Residence of Decedant the Maryland 10b County 10a State 10c. City, Town or Location 10d. Inside City Limits I? Is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examiner must be notified at MD Anne Arundel Severna Park 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 330 Magothy Rd. 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 10 begarnment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Exemples 1 Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: White Specify: þ WW II 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Barber-Owner/Operator Hair Industry 8+ 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be (Unknown) Mary Hanlon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Diane Pelkey/Daughter 330 Magothy Rd. Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dete 20a. Method of Disposition Mar 6 2000 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Metro Crematory Baltimore, MD 4 ☐ Donation ____ Other (Specify) Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 21 Bignature of Poneral Service Ligenses Part1. Elitar tha diseasa, or comp shock, of haart fallure. List only o fions that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, couse on each line. Approximate Interval Batween Onsat and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Heart Failure ongestive Examiner Due to (or as a consequence of) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Exam Severe Ischemic Condiomyopathy Box 68760 physician Physician/Medical å # Atheroscientic Condiovoscular Disease been signed by the attending should be detached for use a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco was contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mellitus Division of Vitai Records, p 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Hypertension After this certificate has Renal 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case raferred to medicel examiner? 26. Placa of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: if or Attending P 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicida To the Hospital within 24 hours a To the Funeral D to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 03/04 70055556 MD 2000 PRIESH 30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print) 64 St ANNAPOLIS, MD Franklin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 9 2000

DHMH 16 Rev 6/95

nec \$ 0 308

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Ruth Blair 27,2000 Jarch 4b. City, Town, or Location of Death 4c. County of Death Baltimore Square Hospital Center Kosedala 6. Sex 7. Age (In yrs. last birthday)

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Anna 6:15AM /Medical 4a Facility Name (If not institution, give street and number) Examiner Tranklin If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 26, 1919 5. Social Security Number Birthplace (State or Foreign Country)
 WY **Funeral** Days 1 M 2 F Months 80 Director 232-28-2106 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore Dundalk 1 Yes 2 No Director 28a-f 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Norms 23a 7488 German Hill Rd. 21222 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 M No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Housewife Own Home air, Anna 17, Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental William Faulkwell Bertha Elizabeth Beard 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a fragorisant: If lean 27 is any injury or other tra otics. Bernard Blair 1787 Brookview Rd. Dundalk, Md 21222 son Date 29 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ory, cremetory or other place)

National Cem Mar 1 Burial 2 Cremation 3 Removal from State Balto. 4 ☐ Donation 5 ☐ Other (Specify) 2000 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Puneral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure out only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Spirator Examiner Examiner eroderma physician and the burial-transit be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai Due to (or as a consequence of): The law requires that the death certificate signed by the at d be detached for P.O. | Part II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, þ should s 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? page 2 s 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) examiner/ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funerai 27. Manner of De 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Panding investigation 1 Yes 2 No death. after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hosp within 24 ho To the Fune completaly fi

29b. Signeture and title of confifier 29c. License number 29d. Date signed (Month, Dey, Year)

ummens.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

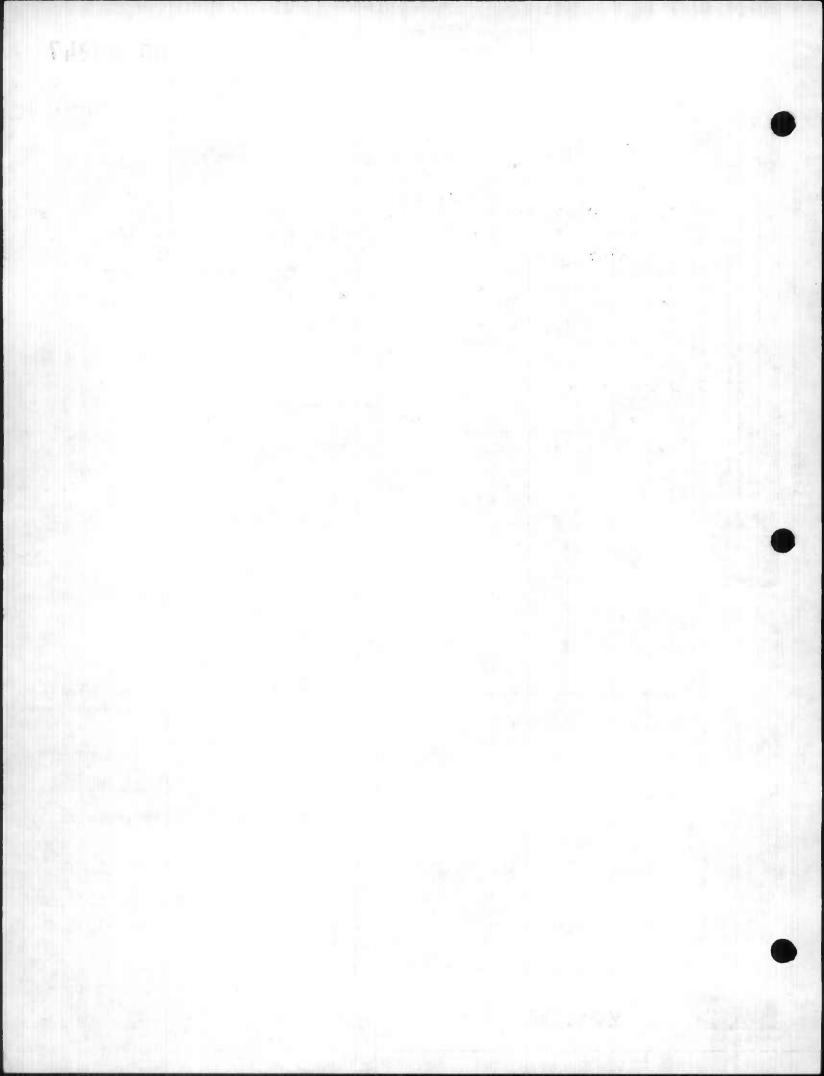
Square Drive Baltimore, MD21237 gwanda 000 Franklin 5 Jummer. 31. Date filed (Month, Day, Year)

State Registrar

MAR 2 7 2000

A A EEE

32. Registrar's Signature Dener

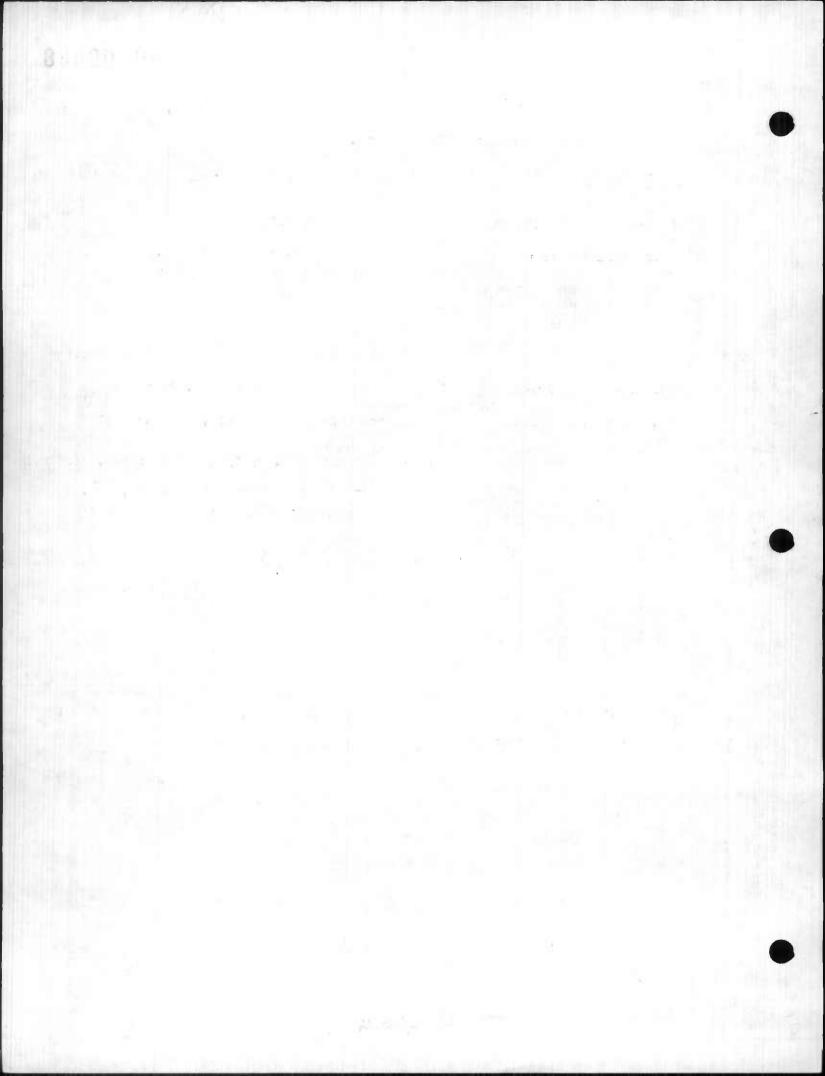


State of Maryland / Department of Health and Mental Hygiene 0 0 9848

			Cei	rtificate of	Death	Re	ig. No.	7040
Physician /Medical	Decedent's Name (First, Middle, Last,	William	Otis	Bickers		2. Data of Death Month March	Day Year 23, 2000	3. Time of Death
Examiner	4a Facility Name (If not Institution, give	street and number)			4b. City, Town, or L		4c. County of Deat	
	Genesis Heritage		ldercare		Dundal		Baltim	ore
Funeral Director	5. Social Security Number 6. Security Number 213-07-0904	7. Age (In 91	yrs. last birthday) Yrs.	If Under 1 Yea Months Days		8. Data of Birth (Month, Day, Aug. 25	Year) Co	hplace (State or Fore unity) ginia
with the Maryland a or 28s-f show be notified at	10a. State 10b. County	timore 100	c. City, Town or Lo	ocation	Dundalk			10d. Inside City Lin 1 ☐ Yes 2 🖾
th with the Ma 23e or 28e-f s unt be notified		kway		10f. Zip Code	21222	10	Og. Citizen of What Co United St	
ors after dealer, or flame Examiner in	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☑ Yas 2 ☐ No If Yes, Give		Was Decedent of II Yes, specify Cu 1 ☐ Yas 2 ☑ No	Hispanic Origin? (Sp ben, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ama Black, White Specify: Wh	
ad within 72 ho ygiene. ser than "natur it, the Medical.	15. Decedent's Edu (Specify only highast grade		(Give	dent's Usual Occi	e during most of work	ting	16b. Kind of Business/	Industry
See See	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retir				
			Ste	eel Work		- (First Briddle B		ndustry
Ald be Aleman Al	William Hume Bio					e (First, Middle, N Bessie G.		
S and a series	19a. Informant's Name/Relationship (Ty Mr. Lawrence Garr				of and Number or Rule o Road Du		City or Town, State, 2 laryland 2	Zip Code) 21222
Pages 1 and hert of Health int: If Item 27 ary or other b	20a. Method of Disposition 1 Disposition 2 Cremation 3 R 4 Donation 5 Other (Specify)			matory or other pi	1		20c. Location - City or Baltimore	
Departs Departs Imports any inju	21. Signature of Funeral Service License		F	Name and Add	Funeral	Home of	Dundalk, I	
	23a. Part1. Enter the disease, or complishock, or heart tailure. List only or	cetions thet caused the	death. Do not ent	222 Wise	Ave. Dur	dalk, Ma	ryland 21	Approximata
Physician	shock, or heart tailure. List only or	e cause on each line.						Interval Between Onset and Deat
/Medical	Immediete Cause (Finat	Car	000 4	1 6	unee			Marle
Examiner	disaase or condition resulting in death)	Due	to (or as a consec	quence of):	8		1 1	701000
ficate be executed) physician end is the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	Dua	to (or as a consec	quence of):			 	
renti ding	resulting in death) Last	Duá t	to (or as a conseq	uence of):			1	
that the death cered by the attendir detached for use	Part II. Other algorificant conditions con	tributing to death but not	t enquiting in the co	ndodrina asusa s	in a final f	22h Didto	bacco usa contributa	to the enues of de
by the tached tached	Part II. Other significant conditions con			noenying cause s	Parti.			robably 4 Dunt
gned to be det	acution	slent	- 4	ear	de seas	e in	2010 0011	outing vigorin
		absti	uls	V Su	y Rise	24a. Was er	ned?	Wera autopsy findi available prior to completion of caus of death?
sician: The law requir certificate has been a irector, page 2 should D Be Completed	Lengt	no			•	1 □ Ye		1 ☐ Yes 2 Ø No
clan	25. Was case referred to medical exeminer?	ospital		10	Wher	Check only on		
Physician: this certificated director,	1 Tes 2 Line	1 Li Inpatient	2 ER/Outpatier	II JUOA	4 Luniursing H		nce 6 Other (Sperior injury occurred	cify)
After funer	1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	ir) Injury	W	ork? □ Yes 2 □ No	200. Describe 110	w injury occurred	
or Attending after deeth. Director: After Jin by the fune ertification	2 Accident Investigation 3 Suicida 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str pecify)			281. Location (St. City or Town	reet end Number or Ru , Stete)	urel Routs Number,
To the Hospital or Attending Physician: The is within 24 hours after deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying Physical Examination Check only one Certifying Physical Examination Ce	Ician: To the best of my er: On the basis of exar and manner stated.						
Me the	29b. Signature and title of certifier			29c. Lice	nse number	25	9d. Date signed (Mont	h, Day, Year)
+ 3 + 8	MOULTA	1-1		Do	0300		2/201	100
7	20000	20	// · · · · · · · · · · · · · · · · · ·	NO.	0)) 8	10 -	0/64	00
9	30. Name and address of person who co	ATRIC	10	101 89 C	Ct . KT	D 212	34	2
State Registrar	31. Date filed (Month, Day, Year) MAR 2 7 2000	32. Registrar's S	ignature /					

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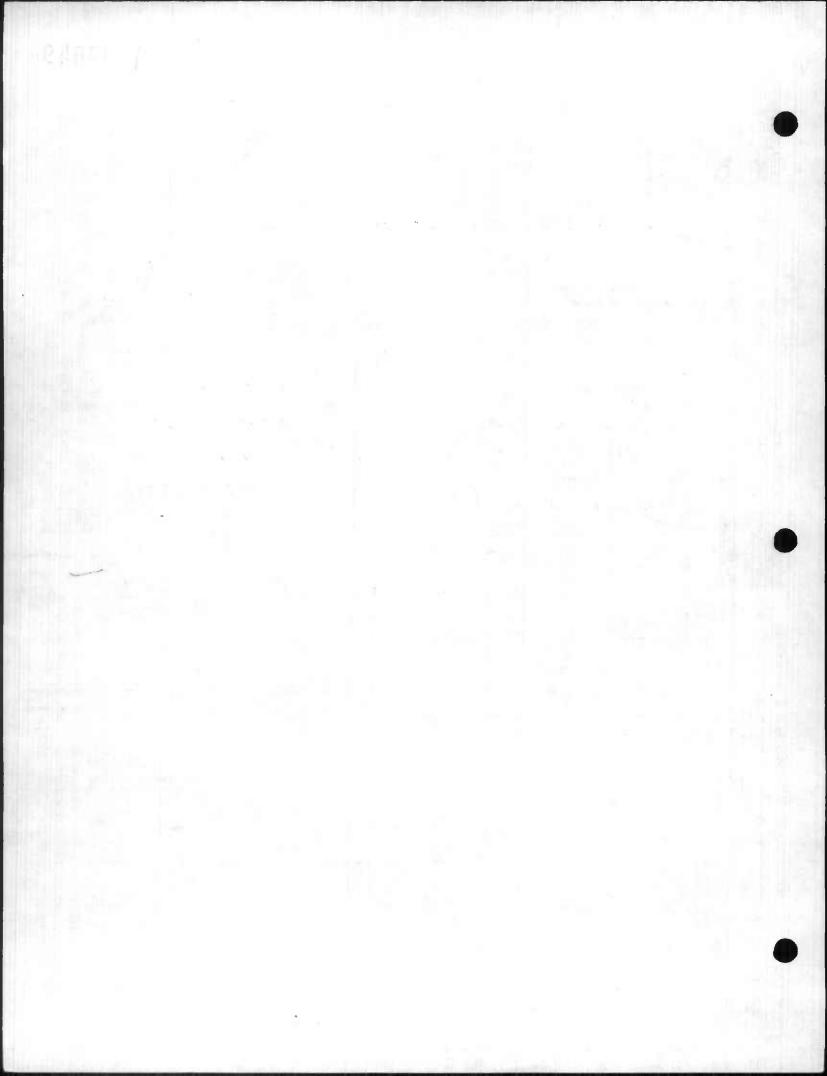
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State of Maryland / Department of Health and Mental Hygiene 00 09849

			Ce	rtificate	of I	Death		Re	eg. No.	, 0	7047
Dhuaisian	1. Decedent's Name (First, Middle, La	ist)		18-				2. Date of Deat	h	.Veer	3. Time of Death
Physician /Medical	Julia Ras	spe B	lacklo	ck				March 2	23 ^{Day} 200	Oreal	1:45PM
Examiner	4a Facility Neme (If not institution, given							cation of Death	4c. County Balti		
	College Manor			T Williams		Luthe			Balti		
Funeral Director		Sex 7. Age (In yn 1□ M 2⊠ F 93	s. last birthday Yrs.	Months	Days	Hours		8. Date of Birth (Month, Day, June 26,	Year) 1906	9. Birthp Coun MI	place (State or Foreign ntry)
Am Am	10a. State 10b. County	10c. C	City, Town or L	ocation						1	10d. Inside City Limits
with the Maryland a or 28a-f show be notified at Director	MD. Baltimo	ore Lu	uthervi	11e	Code			110	0a. Citizen of V	Vhat Cour	1 ☐ Yes 25 No
# ° A O	300 W. Seminary	Ave. 12. Was Decedent Ever in	116 10	210	93	ianania Osi	ning (Sm	ecify Yes or No-	USA		can Indian.
o20 ura eft elf. or by F	3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	0,3.	If Yes, apecil	fy Cuba	n, Mexican	i, Puerto	Rican, etc.)		k, White,	etc.
1 21215-002 ed within 72 hours ygiene 'retural', r, re leaded by	t5. Decedent's E		(Give	dent's Usual	done o	durina mos	t of worki	ing	16b. Kind of Bu	siness/Inc	dustry
within then then then	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)			- 7		
Co Property Co		5+	Prin	cipal		19 Mothe	r'e Nome	(First, Middle, A	Educa		
ylanc ould be fi Mental H arked ott artic ever						Bert		(unknowr		0/	
Maryland 212. d 2 should be filed within and Marual Hygiene. T is marked other market traumatic event, the texturn To Be Comp.	t9a. Informant's Name/Relationship	Type Print)	19h Mail	ing Address /	(Street		_	al Route Number,		State Zin	Code)
2 0000		ep- daughter)						ore, MD.			
other v	20a. Method of Disposition	20b.	Place of Disp	osition (Name	e of				20c. Location -		own, State
Pages ent of th: If If	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		illtop				13	/25/2000	TOWS	on, N	MD.
Baltimore	21 Gignature of Funeral Service Lice			2. Name and				/ 25/ 2000	3 1005	0117 1	
m sages	1.	1' (1)	Ruck	k To	wson	Fune	eral Homowson, M	e, Inc.	14	
	23a Part Enter the disease, or com-	plications that caused the on	ath. Do not en							-	Approximata
Physician	or neart failure. List only	one cause on each line.	Superior Contract of the Contr							1	Intervel Between Onset end Deeth
/Medical	Immediate Cause (Final disease or condition	· Str	ske_							1	2 weeks
Examiner	resulting in death)	a. Due to	(or as a conse	quence of):					4	1	
2 5 5		Atheros	scles	otic	(050	lio	Vasca	lard		
owecuted in and sel-transit	Sequentially list conditions,		(or as a conse					vasca	Bea	2	
58760, cate be esecu- physician and the bunkling	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events										
8 # # OP	that initiated events resulting in death) Last	Due to	(or as a conse	quence of):							
2 5 5 Z		d								i	
Box nath card for use											
s, P.O. Box ne that the death ce gned by the attend be detached for use by Physician/	Part II Other significant conditions of	Α		underlying car	use giv	en in Part f					o the cause of seath?
Part Part V	bernicion ?	Anem	19					10 Ye	s 2□No	3 Prol	bably 4 © Unknown
								24a, Was e	n eutopsy		ere autopsy findings
COr . requ								perform	ned?	CO	railable prior to empletion of cause death?
al Record The law requin ate has been a page 2 should Completed								1 🗆 Ye	s 2 DNo		☐ Yes 2☐ No
Vital Intellection of the Co	25. Was case referred to medical					26 Diago	A Doot	(Check only on	100	11.	
refelan a certifi director	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DO/	Oth	or. /		me 5 Reside		er (Snecil	6/1
Physical articles	27. Manyer of Death	28a, Date of Injury (Month, Day Year)	28b. Time o	3000 000	c. Injun			28d. Describe ho			"
Vision Attending in death, sector: Alter funes by the funes iffication	1 ⊡Natural 5 ☐ Pending 2 ☐ Accident investigatio		Injury	М		Yes 2	No				
Division of Vital air or Attending Physician: The atter death: The there death: The physician: The air by the funeral director, particular to the Certification: To Be Co	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined	28e. Plece of tnjury - At building, etc. (Spec	home, farm, st	treet, factory,	office			28f. Location (St. City or Town		er or Rure	al Route Number,
O stant		Summing, Sto. (Spot	~y,								
DIVISI To the Hospital or Atten- within 24 hours after dear To the Funeral Director. competely filled in by the Medical Certifica		nysician: To the best of my kr niner: On the basis of examin and manner steted.									
D STATE N	290. Signature and title of certifier	Mulon		29c.	Licens	o number	210	19 2	9d. Date signed	d (Month,	Day, Year)
\$	30. Name and address of person who	completed cause of death (ftr	em 23a) (Type	, Print)	0	1-2	, 0		7	R	14
_	21 Date filed (Month Day Vacri	22 Parishada Sir)e11	50		0, 1	un	1 VEIS	173	132	is mare
State Registrar	31. Date filed (Month, Day, Year) MAR 2	32. Registrar's Sign	nature encodes	1.	Kni	21 Km	/		/		
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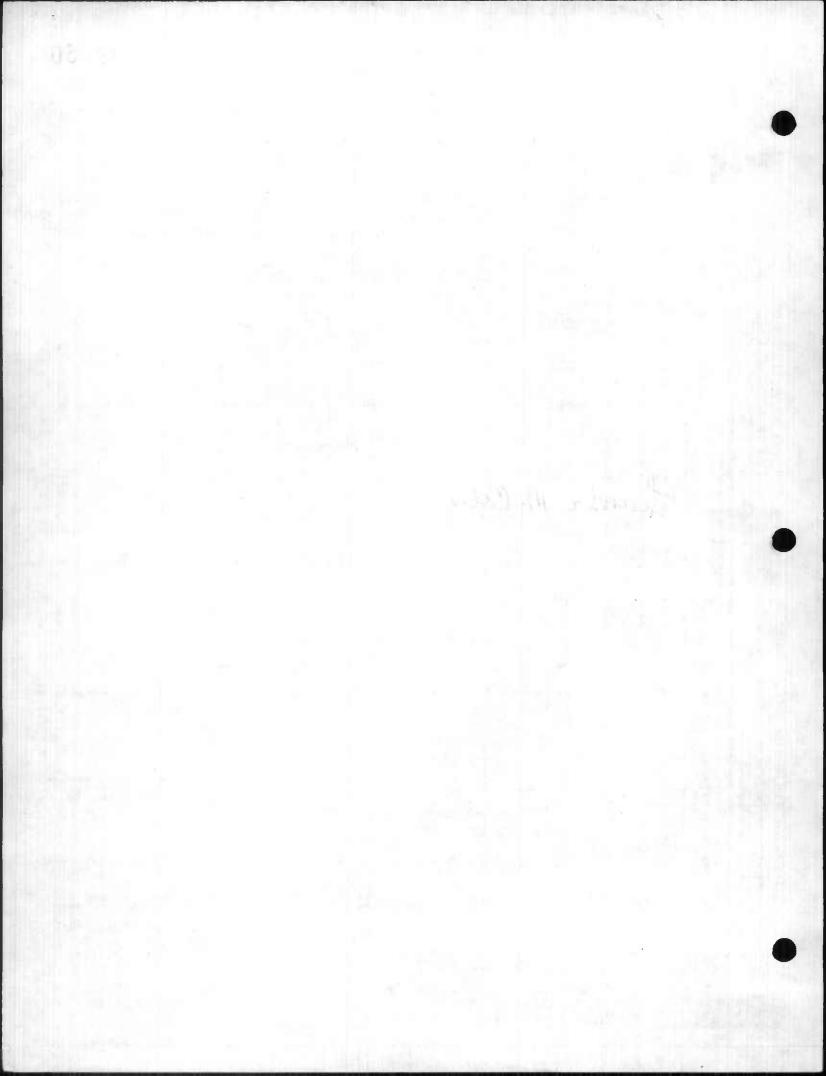


State of Maryland / Department of Health and Mental Hygien 0 0 9850

					Certificate of	Death	Re	g. No.	03030	
	Physician /Medical	Decedent's Neme (First, Middle, Le JAMES BOST	est)				2 Date of Death	Dey Y	3. Time of Des	op 1
	Examiner	4a Facility Name (If not institution, given Stella Morris		Mercy H	Hospital	4b. City, Town, or L Baltimo		4c. County of		
	Funeral Director	2.0 30 2047	Sex 7. Age 1 M 2 □ F	(In yrs. last birt	thday) If Under 1 Yea Months Days		8. Data of Birth (Month, Day,	Year) S	. Birthplece (State or Fo	vreign
Maryland	or 28a-f show be notified at Director	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, Town					10d. Inside City LI	
th with the		10e. Street and Number 1227 Patomac	Street		10f. Zip Code 2121	3	10	g. Citizen of Wh	at Country?	
0020 hours after des	ar, or hams Examiner in by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Wes Decedent of If Yes, specify Cu		pecify Yas or No- Rican, etc.)	Black,	American Indien, White, etc. Black	
Maryland 21215-0020	yglene. we than "natur r, the Madical. Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	upation e during most of work	cing 1	16b. Kind of Busi	ness/Industry	
212 d within	the Man	Elementary/Secondary (0-12) 7 th	College (1-4or 5-	-)	of Employe			Pain	ter	
pus s	B von	17. Father's Name (First, Middle, Last Albert Bost)			18. Mother's Nerr	e (First, Middle, M			
Pyle Pould	To To	19a. Informant's Name/Relationship (Tuna Printl	106	Mailing Address (Stree		nce Bla		eto Zin Code)	
	27 ls or 17	Evette Bost /			227 Pator					
Baltimore,	ant: If item art: If item ary or othe	20a. Method of Disposition 1		DON Dines of	Disposition (Name of y, crematory or other plus Zion Ceme	aca)	Dete 2	Oc. Location - Ci	ty or Town, State	
Balt	Depart Import any inj anos	21. Signature of Funeral Service Lice	m. Col	Per les	Pri-State 108 West	ress of Eacility Te Funer North	al Serv Avenue	ice		
//	ysician Medical saminer	23a. Paff 1. Enter the disease, or com shock, or heart failure. List only framediate Cause (Finel disease or condition resulting in death)	Esop	hage	el Can	ses.			Intervet Between Onset and Deat	n Jh
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	0 4	L	d	1754						
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al Rec	cate ha						1 ☐ Ye	s 2 No	1 Yes 2 No	
of Vita Physician:	s certificate director, pag To Be Co	25. Was case referred to medical examiner?	Hospitel:			at it.	th (Check only one		MARIS AT M	ERE
Vision of	in. After this of funeral din	1 Yes 2 No 27. Maneer of Death 1 Netural 5 Pending investigatio	1 ☐ Inpatien 28a. Date of Injun (Month, Day	28b. T	ime of 28c. Injury	4 LI Nursing H	28d. Describe ho		(Specify) HOSPic	<u>e</u> E
5 6	24 hours after death. Funeral Director: After this staly filled in by the funeral dical Certification:	3 Suicide 6 Could not b		ry - At home, far (Specify)	rm, street, factory, office	9	281. Location (Str. City or Town	reet end Number , Stete)	or Rural Route Number,	
To the Hospital	Funeral Control of the control of th	29a. Certifier Cortifying Ph (Check only 2 Medical Examone)	yelclan: To the best of niner: On the basis of a and manner stat	examination and	death occurred at the Vor investigation, in my	time, date end placa opinion, deeth occur	red at the time, da	ite end place, an	d due to the cause(s)	
Tot	Me Me	29b. Signature and title of certifier	m fu			10854	N)	ARCh	23, 2000	2
	N	30. Name and address of person who DAVID RISED,	ER9 3	30/ ST	PAUI PI	, B.	Himor	RE M	d 21202	
	State Registrar	31. Date filed (Month, Day, Year) MAR 2 7	2000 32. Registra	- Charles	13. 15000	urs/				

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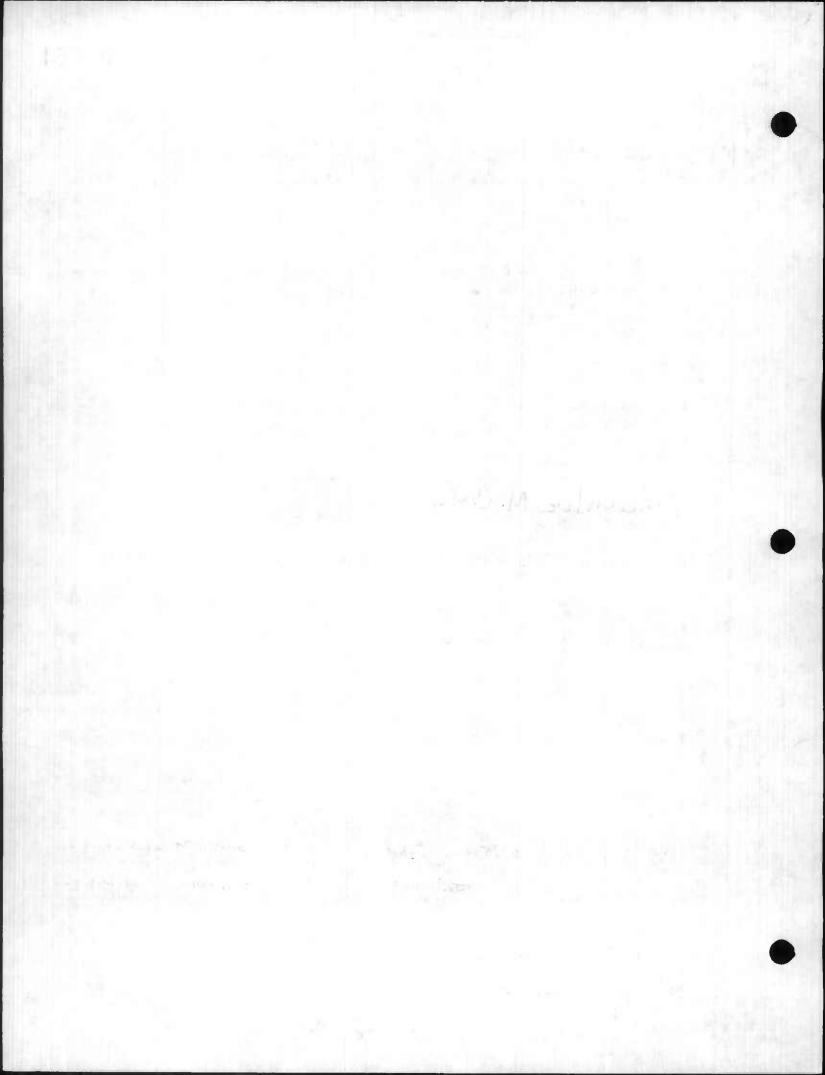


ASP	DKEW	C.K.	State of	Maryland /		rtment of H		d Mental Hy	rgiene () (0 0	9851
		1. Decedent's Neme (First, Middle,	Last)	12.11	7 74	15.77	113	2. Dafe of De Month	eath Day	Year	3. Tima of Death
	Physician /Medical	Derrick D. Br	rewer					MARCH		000	6:12 A
	Examiner	4a Facility Neme (If not institution, JOHNS HOPKINS		ber)			4b. City, Town, BALTIM	or Location of Deal	h 4c. County	of Death	
	uneral irector	5. Social Security Number 213-98-4749	6. Sex 1 ★ 2 □ F	Age (In yrs. last	birthdey)_ Yrs.	If Under 1 Yeer Months Deys		lin. (Month, D	25.80	9. Birthpla Country MD •	ce (Stete or Foreign y)
ba		Usual Residence of Decedent 10a. Stafe 10b. County		10c. City, To	oum or l on	ation				40	d Anaida Ciba I Imila
e Maryta	tiffed at ctor	MD .			timo					100	d. Inside City Limits YEVes 2 □ No
th with th	23a or 28a-f show ust be notified at al Director	10e. Street and Number 4211 Ivznhoe	Ave.			10f. Zip Code 21212	2		USA	What Countr	y?
020 ours after dos	al', or lisms Examiner m by Funer	11. Marital Status 1	Armed Ford	- DANK		Ves Decedent of H Yes, specify Cub	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	Blee	e - Americei ck, White, et Blac	c.
Maryland 21215-0020 at 2 should be tiled within 72 hours at the and Mental Hygiene.	nt, the Medical Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		10 (or 5+)	(Give k	ent's Usual Occup ind of work done O NOT use retire PAIR	pation during most of d)	working	16b. Kind of B		ovement
land 2	ked other ic event, g	17. Father's Name (First, Middle, L Derrick D.		Sr.				Name (First, Middle ldine K		ne)	
Mary nd 2 shou	27 is marrier traumat	19a Informant's Name/Relationsh Patricia A.	Brewer/,9	rand				Rural Route Numb			Code)
Baltimore,	nd: If flam ary or othe	20a. Method of Disposition T Burial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from St	20b Place	of Dispos	ition (Neme of etory or other pla 1 Cemet		Date	0 Land	City or Tow	
Balt permit.	eny inports	21. Signeture of Funeral Service L	icensee M. (Poles	22.			neral S	ervice		
/M	sician edical miner	23a. Part 1. Enter the disease, or of shock, or heart failure. List of the control of the contro		LOT WOU Due to (or as	2 cm	TO CH			D BUTT		Approximate nterval Between Onset and Death
ox 68760, certificate be executed	attending physician and for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b c	Due to (or as							
, P.O. Box that the death cert	ache thys	Part II. Other algnificant condition	na contributing to dea	th but not resultin	g in the un	derlying ceuse giv	ven in Part I.		tobacco usa co		the cause of death?
ords,	should be d		b. File	Sur				24a. Wa	s an autopsy formed?	avai	re autopsy findings lable prior to apletion of cause eath?
I Rec	page 2							W F2	Yes 2□No		Yes 2□ No
	certificate rector, pag	25. Was case referred to medical					26. Place of	Death (Check only			
		examiner? 1 ☑ Yes 2 ☐ No	Hospital:	patient 2 ERV	/Outpatient	3 DOA OH	hor:	ng Home 50 Res		ner (Specify)	
C 2	uneral uneral	27. Manner of Death 1 Natural 5 Pending 2 Accident Investign	28a. Date of (Month,		b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occur	red	
Visio	Director: / d in by the d ertificat	3 Suicide 6 Could no 4 Homicida determin	of be 28e. Place o	Injury - At home	, farm, stre	et, factory, offica		28f. Location City or To	(Street and Numi	ber or Rurei	Route Number,
spits hours	ai y	29a. Certifier 1 Certifying	Physician: To the b	est of my knowled	dge, death	occurred at the ti	me, date and p	4211 PA	ANDE P	anner as sta	ited.
To the Ho within 24	To the F complete	29b. Signafare and title of certifier	and menne			29c. Licens			29d. Date signe MARCH		Pay, Year)
W	State	30. Name and address of person w A WA (WA) 31. Date filed (Month, Day, Year) MAR 2 7	1. Kons	of death (Item 23 UM), gistrar's Signature		111 Pe		et, Balt	imore, M	arylar	nd 21201
	Registrar	t	-000		12.	poor	62/				

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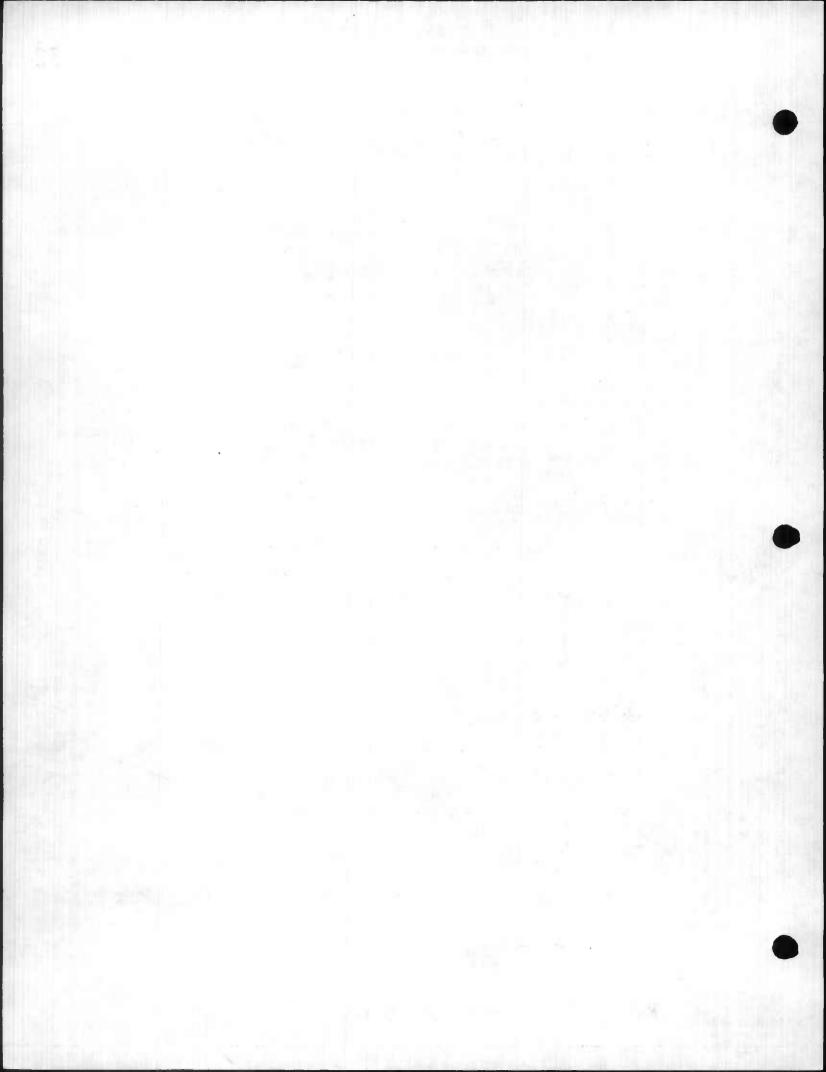


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 23, **Physician** 9:20 A.M. Viletta Elizabeth Calvert March 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Frankford Nursing & Rehab. Center Baltimore N/A H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 11, 1917 Pennsylvania 7. Age (In yrs. last birthday) If Under 1 Yaar Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 10 M 2 X F 83 Director 172-14-5636 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location t 0d. Inside City Limits r than "natural", or Nama 23a or 28a-f ahow the Mexical Examiner must be notified at 1 X Yas 2 □ No Directo Maryland N/A Baltimore 10f. Zip Code 10e. Street and Number 10c. Citizen of What Country? 21205 5320 Wright Avenue U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - Amarican Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 8 Pages 1 and 2 should be nent of Health and Mental Is marked Benjamin Gibson Hester J. Jennings 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau William G. Herold (Son-in-Law) 5320 Wright Avenue, Baltimore, Maryland 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/25/200 Baltimore, Maryland 4 □ Donation 5 □ Othar (Specity) Green Mount Crematory 22. Nama and Addrass of Facility
Schimunek Funeral Home Inc. 21. Signature of Funeral Service/Lice 3331 Brehms Lane, Baltimore, Maryland 21213 or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, ist only one cause on each line. **Physician** Stayl Cluric Obstructing
Due to (or as a consequence of): Cury desease /Medical Immediata Causa (Final disassa or condition resulting in death) Examiner Examiner iclan and burial-transit Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical phys the Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part II. 23b. Dtd tobacco use contribute to the cause of death? P.O. 1 Yaa 2 No 3 Probably 4 Winknown signed be det by Records. 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No of Vital 25. Was case rafarred to made examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 70 1 Yas 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mannet of Deat 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: Division Attending 1 (DiNatural 5 Pending To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, tarm, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number mm cy HARTORD POSO Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 3 1 co to PATEI CIU RAA RULAMP 31. Data filed (Month, Day, Year) MAR 2 7 2000 32. Registrar's Signature State Docks Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 amend item 7 per fh G781 3/27/00 yg Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year Physician arr 3:00 Pm har March 23 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balti more 8. Data of Birth (Month, Pay, Year) 08-17-58 HOPKINS Johns tal Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (Stata or Foreign Country) Funeral Days Hours ¥ØM 2□F 51 41 Yrs. 217-66-6075 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1 Yas 2 No Director 288-4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21213 USA 3343 Lyndale Avenue Berra 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Biack, Whita, atc. 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: >> Never Married 2 ☐ Married 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry J.H.H. Elementary/Secondary (0-12) I2th Grade College (1-4or 5+) Laborer Manganaro Corp. permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Nem 27 is manked oth any Injury or other traumatic event 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be Thelma Giddiens James C. Carr 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2430 Ashland Avenue Baltimore, Maryland Thelma Carr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata MD. 20a. Method of Disposition Data ty☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem.Pk. Cemetery 02-28-2000 Randallstown, of Funeral Service Licens 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvsl Batween Onset and Death **Physician** /Medical Immediata Cause (Final Brain diseasa or condition resulting in death) Examiner Examiner 10 hours Herniation physician and s the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, ntracranial hemorrha Physician/Medical The law requires that the death certificate Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records. 2 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 No certificate 1 Yas 2 No of Vital or Attending Physician: funeral director, 25. Was case refarred to medical axaminer? Be 26. Place of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1) Inpetient 2 ER/Outpetient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After 1 Maturel 5 Pending after death. Director: Af 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 4 ☐ Homicide filled in Hospital 24 hours a Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. Medical 29a, Certifier To the Hosp within 24 ho To the Fune compietely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

31. Data filed (Month, Day, Year) 2000 MAR 27

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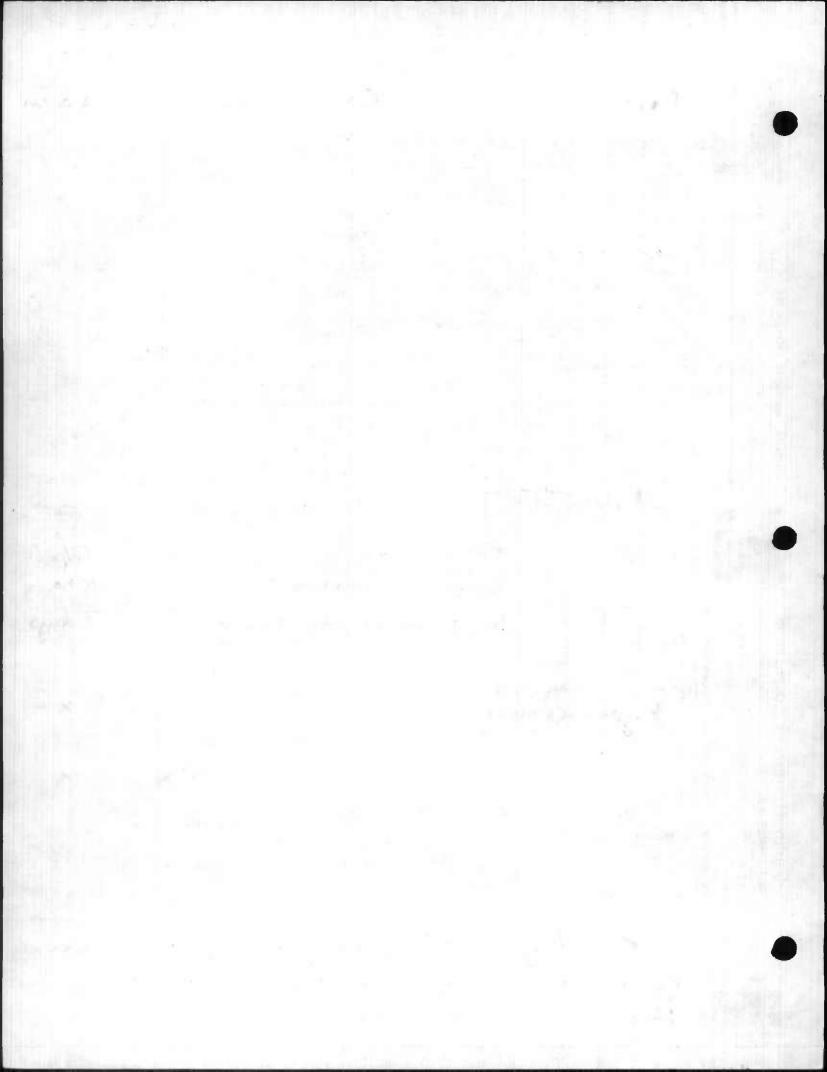
March 23, 2000

30. Name and address of person who completed cause of death (lifem 23a) (Type, Print) Yohau

600 Street Baltimore MO North water

32. Registrar's Signature work,

MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death CARDELL CHAMBERS 15:20 22,2000 MARCH 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death HOSPITAL BAYVIEW BALTIMORE HOPKINS JOHNS 6. Sex 1 M 2 F If Under 1 Year Months Days Social Security Number 7. Age (In yrs. jast birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 216-74-844 Hours Usual Rasidence of Decedan 10b. Coun Stala 10c City, Town or Location 10d. Inside City Limits 1 Yas 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? add 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Meritel Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Nevar Married 2 Married 1 Yes 2 No If Yes, Giva Year or Dates: ack 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ndary (0-12) College (1-4or 5+) Worked Mother's Nama (First, Middle, Maiden Sumama) 17 Father's Nama (First, Middla, Last) 19a. Informant's Name (Relationship (Type 20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data 1 Buriel 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State 4 Donalion 21. Signature of hase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, in. List only one cause on each line. Approximeta Interval Between Onset and Death Immediate Causa (Final disease or condition rasulting in death) MONTH SEPSIS Due to (or as a consequence of): 6 WEEKS DIABETES Sequentially list conditions, if any, leading to immediate causa. Enlar Undarlying Cause (Disease or injury Due to (or as a consequence of): that initiated events rasulting in death) Last Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 200 No 3 Probably 4 Unknown 1 Yes 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? ZZNO 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical examiner? 26. Place of Death (Check only one) 1 Yas 25 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Investigation 1 TYes 2 No 2 Accidant 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, tarm, street, factory, office building, etc. (Specify) 4 Homicide DECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner The law requires that the death certificate be executed Box 68760. P.O. 1 Records. Division of Vital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

al', or items 23s or 28s-f show Exerciper must be notified at

"natural", or

th and Mental Hygiene.

7 is marked other than "natur traumatic event, the Medical

Pages 1 and 2 should be fament of Health and Mental I int: if Nem 27 is marked of

permit. Pages 1 and Department of Health Important: if hem 27 eny injury or other tropace.

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signed by the at d be detached for

page 2

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After

Physician/Medical Examiner

Completed by

Medical Certification: To Be

(Check only one)

29b. Signeture and titla of certifian

aure

Funeral Director

Completed by

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the Maryland

with

death

filed within 72 hours after

21215-0020

Baltimore, Maryland

24 hours after death.

Funeral Director: A filled in by Hospital completely To the To the To the I

DHMH 16 Rev 6/95

State Registrar

31. Data filed (Month, Day, Year)

ZAAS, MD, 600 WOLFE 32. Registrar's Signature

faces, MD

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

STREET, BALTIMORE, MARYLAND

29c. License number

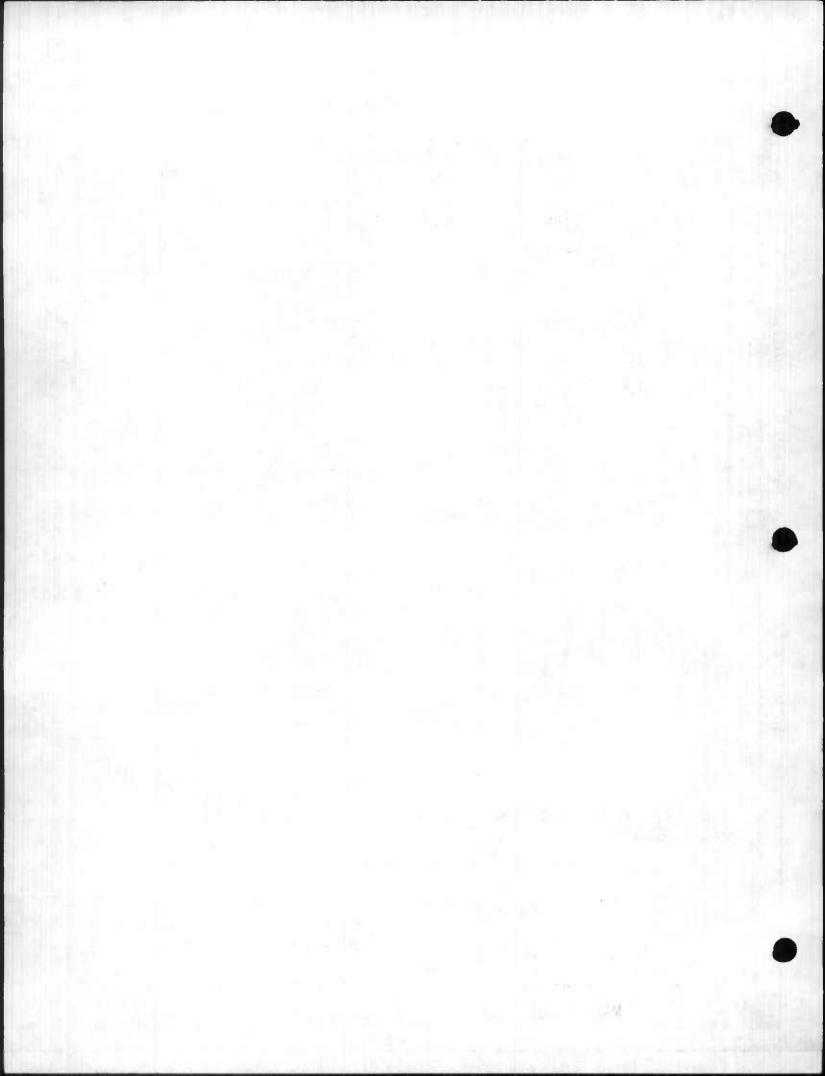
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29d. Date signed (Month, Day, Year)

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MARCH

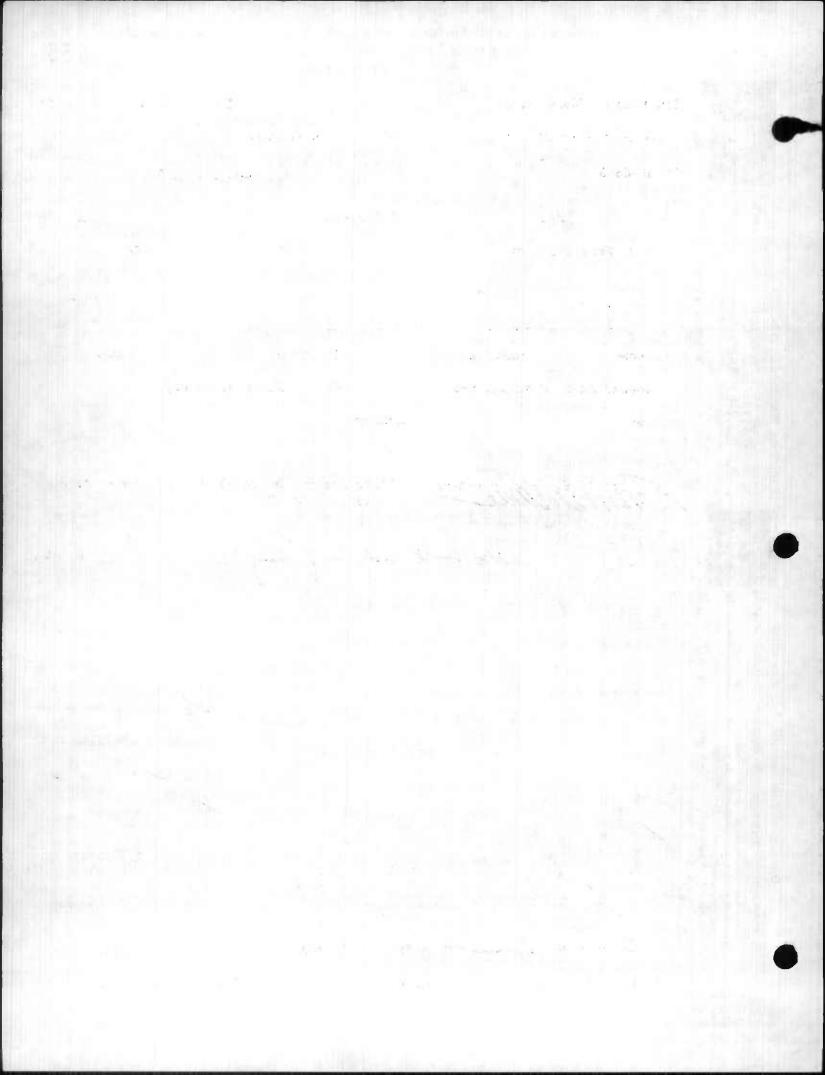
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State of Maryland / Department of Health and Mental Hygiene 0 0 9855

				Cel	tificate	of	Death		F	leg. No.		
Physician	1. Decedent's Nama (First, Middle Jonathan M. Cha								2. Date of Dea		Year	3. Tima of Death 3:00 PM
' /Medical Examiner	4a Fecility Name (If not institution 2224 N. Monro	, give street and numbe	or)				4b. City, To Balti		ocation of Death	4c. County		
Funeral Director	5. Social Security Number 220–36–8646	6. Sex 7. /	Age (in yrs. last	birthday) Yrs.	If Under 1 Months	Yaar Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Dec 31,		9. Birthpl Count	ace (State or Foreig try) MD
2 2	Usual Residence of Decadent 10a. State 10b. County		10c. City, T	own or Lo	cation						11	Dd. Insida City Limit
death with the Maryland one 23a or 28a-f show r numbe notified at neral Director												t¶ Yas 2□ N
fier death with the Marrier remains or 28s-f solder rount be notified Funeral Director	10e. Street and Number 2224 N. Monroe	Street			10f. Zip C	Code	212	17		Og. Citizen of V	What Coun SA	try?
urs after bi', or he Examine by Fu	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 ₺ Divorced	12. Was Deceder Armed Force ied 1 Yes 2 If Yes, Give Year or Datas	s? I No	1	Was Decede if Yas, specif	y Cub	an, Mexicar	n, Puarto	ecify Yes or No- Rican, etc.)		e - America ck, White, a v: b	
naturel', and exemple leted by	15. Deceden	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most or							cing	16b. Kind of B	usiness/Ind	lustry
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be filed lal Hygin d other event, Be Co	17. Father's Name (First, Middla,	Last)							a (First, Middle,		10)	
should be formarked of urmetic eve	Johnathan M	. Chatman,	Sr.				1	Alic	e B. Kei	nney		
0 0 0 0	19a. informant's Name/Relations unknown	hip (Type, Print)			ng Address (known	(Stree	t and Numbe	er or Rui	ral Route Numbe	r, City or Town,	State, Zip	Code)
pemit. Pages 1 end 2 Department of Health. Important: if item 27 i any Injury or other tre RDGB.	20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S)		cem	e of Dispo etery, crer	sition (Name metory or oth	e of her pla	ce)	1	Date	20c. Location -	City or To	wn, State
Physician /Medical Examiner	23a Part Enter the disease, or hook, or heart failure. List transdiate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each	ed the deeth. I	Do not ent	Baltimer the mode	ore of dyi	, MD ing. such es	212 cardiac	or respiratory an			Approximata Interval Between Onset and Death
leath certificate be executed attending physician and for use as the bunial-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as									
iras that the deeth cer signed by the attendin d be detached for use d by Physician/N	Part II. Other eignificant condition	ns contributing to death	but not resultin	ng in the u	nderlying ca	use gi	ivan in Part	l.		/		the cause of deat
as that if									1,2			bebly 4 Unkno
aw requisite the state of the s	- 111 4								24a. Was perio	en autopsy med?	av.	ere autopsy finding: ailable prior to mpletion of ceuse death?
F # 8 0									1 🗆 Y	es 2 No	10	Yes 2010
yaician: The li s certificate he director, page	25. Was cese referred to medica examiner?					0		e of Dea	th (Check only o	ne)		
£ £=	1 ☐ Yes 2 ☐ No	Hospitai:		/Outpatier		-		ursing H	ome 5 Resid			y)
tal or Attending Physics after death. si Director: After this led in by the funeral d Certification: Te	27. Menner of Death 1 Chatural 5 Pendir 2 Accident investignment of Could	pation		M 1 Yes 2 No								
ttal or Att ins after d ai Direct lied in by	4 Homicide detarm	ined 28e. Place of building,	Injury - At home etc. <i>(Specify)</i>	e, farm, str	reat, factory,	office			City or Tou	m, State)	per or Hura	I Route Number,
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:	29a. Certifier 1 Certifyin (Check only 2 Medical	g Phyeician: To the be: Examiner: On the basis and manner	of examinetion	dge, deetl end/or in	h occurred at vestigation, i	t the ti	ime, date ar opinion, des	nd piace eth occur	rred at the time,	date end place,	and due to	the cause(s)
To the complete compl	29b. Signature and title of certifie	a Jun		un	29c.	Lican	se number	(29d. Date aigne	e CC	Day, Year)
	30. Name and address of person			Ba) (Type,	Print) Os/c	_	Dr:	<i></i>	Town	ic u	7	1264
State	31. Date filed (Month, Day Year)		sfar's Signeture		9	1						



State of Maryland / Department of Health and Mental Hygiene 09856 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month Year Physician Botty M Eggloston

4a Facility Name (Injut Institution, give street and rumber) 2000 165 March /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner yrs. last birthday) If Under 1 Yeer Months Days 5. Social Security Number 6. Sex JILLE Baltimore 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 MD **Funeral** Days Hours 1□M 20F 219-28-9598 Aug Director 18, Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director Baltimore Co. Catonsville 288-4 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 709 Maiden Choice Ln 21228 USA "natural", or Items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Merital Status Bleck, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: white Specify: þ 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) poemit. Pages 1 and 2 should be filled with Department of Health and Mental Hygers important if them 27 is marrised other than any Injury or other transmissions. Auditor IRS 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Bessie Davey Andrew Grubert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 Cedarmere Cir., Owings Mills, MD <u> Carol Suplicki - Daughter</u> 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete tOßurial 2 ☐ Cremation 3 ☐ Removel from State 3/27/00 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of Fugural Service Licens 22. Name end Address of Fecility 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD implications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, but it hy one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Preumonio Examiner Due to (or as a consequence of): Examiner physician and the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. signed by t 1 Yea 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? Peripheral Voscular disease hes 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:

Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the After this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: at or Attending P s efter death. If Director: After t of in by the funeri 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) no ne D 30989 March 25 5000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) My Carpenter
31. Data filed (Month, Day, Year) 32. MD Choice In Catonsville

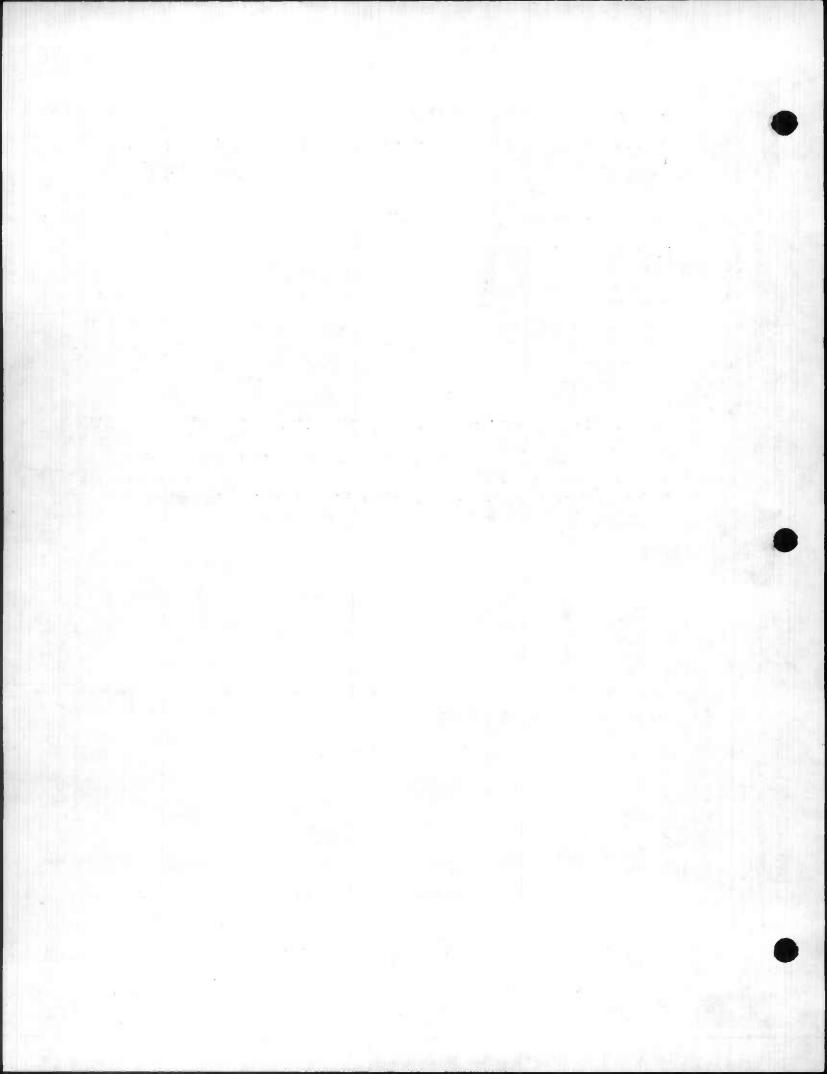
DHMH 16 Rev 6/95

State

Registrar

32. Registrar's Signature

MAR 2 7 2000



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death MARCH TWENTYTHIRD **Physician** FORD 6.25 PM ANNIE /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTMORE BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

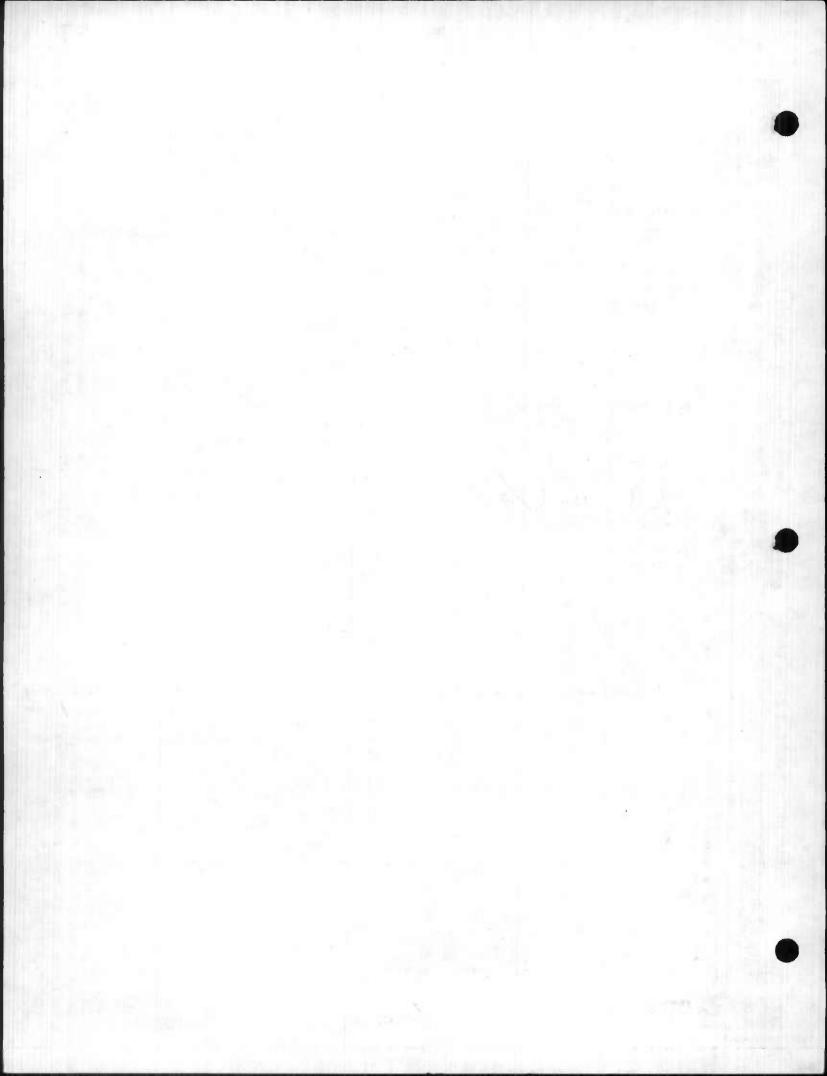
6.5. Months Days Hours Min. (Month, Day Year)

1.0-18-34 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 216-30-5036 Director Usual Residence of Decedant 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits must be notified at MD NA Baltimore 1 No 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5220 York Road Apt. #7-N 21212 USA Name 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※ ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status atte 1 ☐ Never Married 2 ☐ Married "natural", or 1 Yes 2 No Specify: 21215-0020 Specify: Black p 3 Ø Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Etementary/Secondary (0-12) College (1-4or 5+) Cashier Fairfield Liquors 10th Grade Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fit h and Mental H is marked off permit. Pages 1 and 2 should be Department of Health and Menta Important. If frem 27 is marked any injury or other treumeds ever Bross. Lottie H. W. Bond Bazemore John 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Name/Relationship (Type, Print) Ramona Avenue Baltimore, Maryland Pearl A. Chase 3231 Saltimore, 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Nat'l Cemetery03-28-2000 Baltimore, 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service License WM.C.March FH 1101 E. North Avenue nen 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Causa (Final disease or condition resulting in death) SHOCK SEPTIC 5 DAYS Examiner Dua to (or as a consequence of): Examiner C. DIFFICIE COLITIS 2 WEEKS that the death certificate be executed physician and the burial-trans Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Box 68760, MRSA 7 DAYS PNEUMONIA Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISEASE, DYT, signed l Records. p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed SEIZURE DISORDER DEMENTIA page 2 s 1 TYes 2 No 1 □ Yes 2 □ No of Vital 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Division Attending 1 Natural 5 Pending investigation 1 Yes 2 No death. Director: / 2 Accident 6 ☐ Could not be detarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Directally filled in b hours after 6 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of cedifier 29c. License number 29d. Date signed (Month, Day, Year) mall, M.D. P13455 03/23 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOMINI QUE MALL GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLUD
PALTIMORE MD 21239 MAR 2 / 2000 32. Registrar's Signature State oaks Registrar

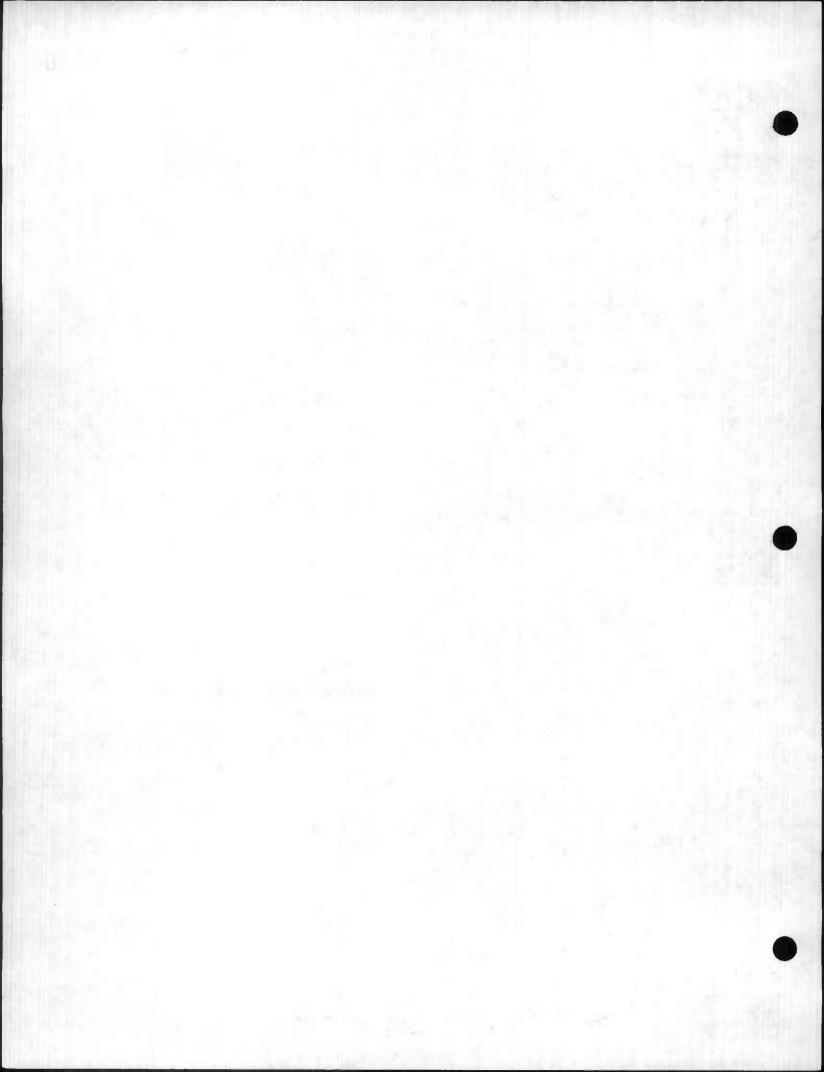
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, Last))	Certificat	e of Death	2. Date of De	Reg. No.	3. Time of Death
Physician	DANIEL F	TowLer			Month MARCH	Day 23, 2	Year 2000 1020 AM
/Medical Examiner	4a Facility Name (If not Institution, give	street and number)	WENT # 220	4b. City, Town, or	Location of Deat		
	1401 LAKEWOOD A 5. Social Security Number 6. Se		MENT # 328	BALTIM		NA	9. Birthplace (State or Foreig
eral ctor		8M 2DF 8	7 Yrs. Months	Days Hours Min		(y, Year)	Country)
rector	10a, State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
ctor	Md. N.A.	3	alto				Ver Yes 2□No
Funeral Director	1401 n LAKeu	sod en ar	1328 21	213		10g. Citizen of V	What Country?
		12. Was Decedent Ever in U. Armed Forces?	1 Vac	dent of Hispanic Origin? (Scify Cuban, Mexican, Puer 212 No Specify:	Specify Yes or No to Rican, etc.)	Specify	e - American Indian, sk, White, etc.
P	15. Decedent's Edu	cation	16a. Decedent's Usua	al Occupation	dina	16b. Kind of Bu	usiness/Industry
Be Completed by	(Specify only highest grad	College (1-4or 5+)	life. DO NOT us	rk done during most of wo se retired) STEF	rkiig	E HU	rch
Se C	17. Father's Name (First, Middle, Last)				1	, Maiden Suman	00)
To	RICHANT	Fowler		MA	ry h	1190	
	19a. Informant's Name/Relationship (Ty	rpe, Print) WLET	19b. Malling Address	S (Street and Number or A	44 0		State, Zip Code)
	20a. Method of Disposition		taca of Disposition (Nar	me of other place)	Date	20c. Location -	City or Town, State
	1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	removal from State	avuson 3	orest Cen	3/31/00	Orrenjo	mullo ma
	21. Signature of Funeral Service Licens	9 15	22. Name ar	nd Address of Facility	. 0 =	/	2011
once. To Be Comp	Joseph D. X	ocks for	Hosep	LB · xous	为人	IH 130	24 B. Central
	23a. Part . Entar tha disease, or complishock, or haart failure. List only or	ications that caused the death	n. Do not entar tha mod	da of dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Batween
ian							Onset and Death
cal ner	Immediata Causa (Final disease or condition	Hypertensive	e Arteriosc	lerotic Car	liovascu	lar Dise	ease
	resulting in death)		r as a consequenca of):				
- el		o					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequence of):				
	Cause. Enter Underlying Cause (Disease or injury that initiated events	s					
edical	resulting in death) Last	Due to (or	r as a consequence of):				
3		J					
licia	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlying o	ause given in Part I.	23b. Did	tobacco use co	ntributs to the cause of death
Completed by Physician/N					10	Yes 2 No	3 Probably WUNknow
by F	CARCINOMA OF THE	LUNG					
pet					24a. Was	en autopsy ormed?	24b. Wara autopsy findings available prior to
ple					INSP	ECTION	completion of cause of daath?
Cou					10	Yes 2000	1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical axaminer?				ath (Check only	ona)	
To	MX162 20160	lospital: 1 Inpatient 2			-	idenca 8 Oth	
ion	27. Manner of Death DNaturat 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe	how injury occur	red
cet	2 Accident invastigation 3 Suicide 6 Could not be	200 Place of Injury Ash	M	1 ☐ Yes 2 ☐ No	29f Location	(Street and Numb	per or Rural Routa Number,
Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, atc. (Specify	oma, tarm, street, tactory	y, office	City or To	wn, State)	er or Aural Adula Number,
CBI		sician: To the best of my kno- ner: On the basis of examinal and manner stated.					
- 6	20120	and manner stated.	20	c. License number		29d. Date signe	d (Month Day Voed
Medical	29b. Signature and title of certifier		231				u (month, Day, 1981)
Medi		11	1	O.C.M.E.		MARCH	23, 2000
Medi	29b. Signature and the of certifier	M.	D			MARCH	
Medi	30. Nama and address of person who co	1 111	1 23a) (Type, Print)		e, Maryl		23, 2000
- N	29b. Signature and the of certifier	ompleted cause of death (Item Stave 111 32. Registar's Signa	23a) (Type, Print) Penn Stree	O.C.M.E.	e, Maryl		23, 2000
State	30. Nama indiaddress of person who co	staner 111	23a) (Type, Print) Penn Stree	O.C.M.E.	e, Maryl		23, 2000

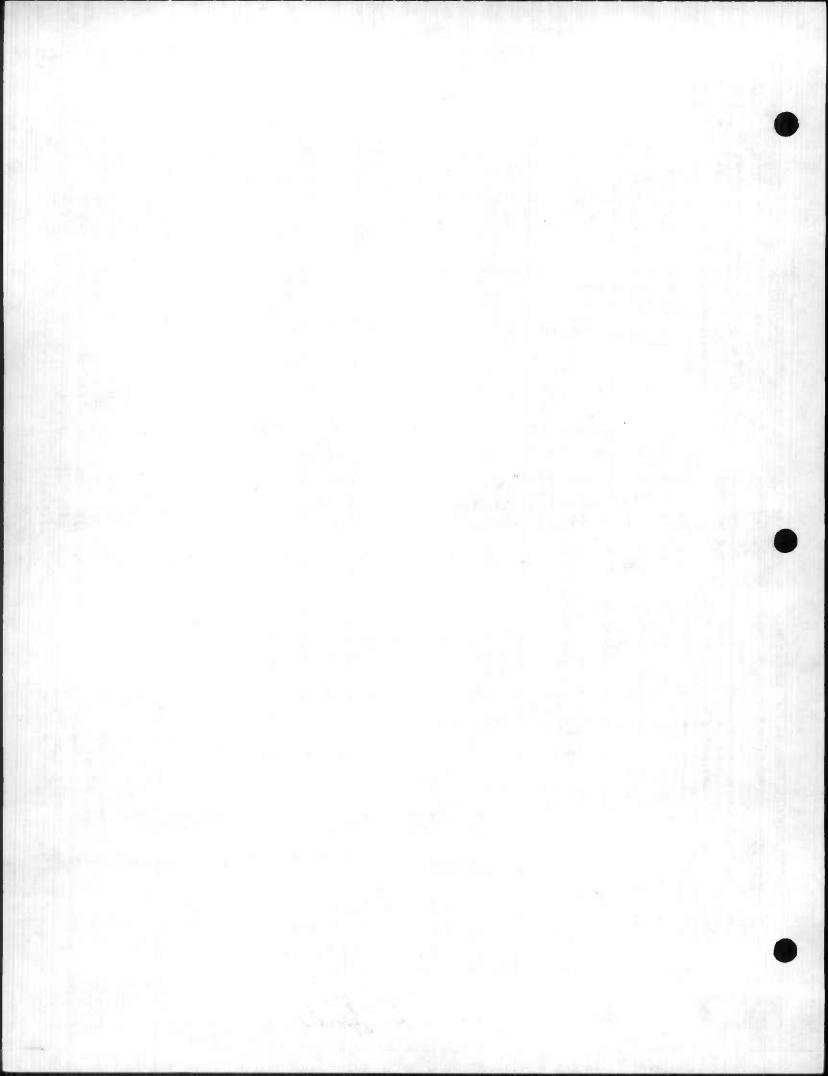
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 09859 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Physician 26, Charles Harry Fewster March 2000 11:45 AM /Medical 4a Facility Nama (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 954 Regina Drive Arbutus Baltimore If Under 1 Year Months Days If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15 M 2□ F 212-30-6081 67 Director March 8, 1933 Maryland Usual Residence of Deceden the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or heme 23s or 28s-f show the Medical Examiner, must be notified at 1 Yas 2 No Director Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 954 Regina Drive 21227 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 DXYss. 2 □ No If Yes, Give Year or Datas: 1952-53 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. 11. Marital Status a filed within 72 hours effer if Hygiene. other then "natural", or ite 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City firefighter 12 Fire Department permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked other eny injury or other traumatic event pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Harry Louis Fewster Margaret Marie Wagener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 954 Regina Drive, Arbutus, Maryland Charlotte E. Fewster - wife 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 3/30/00 Elkridge, Maryland 21. Signature of Funeral Service Lice 22. Nama and Addrass of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland baltimore, No. 1 caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, and on each line. Approximate Intarval Batween Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical AdeNOCARUNOMA OF ESONBAGUS 2 YEAR · Widely METASTATIC Examiner Due to (or as a consequence of): Examiner physicien end is the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yea 2 No 3 Probably 4 Unknown SODYAGECTOM Records, à 24b. Ware autopsy findings available prior to Completed 24a. Was an autopsy performed? DOTENSION completion of cause of death? 1 Yas 2 146 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attending Physicien: director, 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Mesidence 6 Other (Specify) 2000 1 Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manney of Death 28d. Describe how injury occurred 28a. Data of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Matural 1 Tas 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 16200 MARCH 27, ATTENDING 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) DR. N.M. MACHIRAN 720-C MAIDEN Choice LA. CATONSVIlle, 21228 31. Data filed (Month, Day, Year) 32. Registrer's Signatura State 5000 MAR 2 Benevas Registrar

DHMH 16 Rev 6/95



Kareen Green Please Type or Print in Black indelible ink. Assure All Copies Are Legible. 00-1650-510 State of Maryland / Department of Health and Mental Hygiene 09860 -Karin Green amend item 28e per me 3/28/00 yg G781 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day March 23,2000 **Physician** Green 03:22 A.M. Kareem /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hopkins Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-05-77 Birthplace (State or Foraign Country) 7. Aga (fn yrs. fast birthday) **Funeral** XM 20F Months Days Hours 213-90-4488 22 Yrs. MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-(show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 ☒ No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3419 Barry Paul Road Apt. #103 21133 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No It Yes, Give Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) NA Yolando Johnson Co Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) os 1 and 2 should be fi of Heelth and Mental H Nem 27 fa marked out Ellerbe Denise Green Preston 21133 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3419 Barry Paul Road Apt. #103 Randallstown, 19a. Informant's Name/Relationship (Type, Print) Ellerbe Denise 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Pages permit. Pages 1 Department of H Important: if Ne any injury or ot once. 1 Burlal 2 □ Cramation 3 □ Removal from State Woodlawn Cemetery 03-28-2000 Woodlawn, MD. 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 21202 21. Signature of Funeral Service Lic 22. Name and Address of Facility WM.C. March FH 1101 E.North Avenue e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the only one cause on each line. Approximate Interval Batween 23a. Pert1. Enter the disease shock, or heart failure. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner certificate be asscuted attending physician and for use as the bunal-trans Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events Due to (or as e consequenca of) Box 68760 Physician/Medical Dua to (or as a consequence of) rasulting In death) Last P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the causs of death? 8 1 Yes 2 No 3 Probably 4 Unknown been signed by det Records, by 2 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed certificate has page Yes 1 Yes of Vital Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) examiner?
1 Yea 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Dete of Injury. (Mgnth, Day/Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how Injury occurred Division or Attending 1 Natural 5 Pending investigation after death.
Director: Aft
d in by the fu 1 Yas 2 No 23/00 2 Accident 281. Location (Street and Number or Rural Route Number, City or Toym, Staje) 6 Could not be detarmined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 45 Homicide house 0 within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and manner as stated.

**Commonship Physician: To the best of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner steted. edical 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. March 23,2000

State Registrar

DHMH 16 Rsv 6/95

31. Date tiled (Month, Day, Year)

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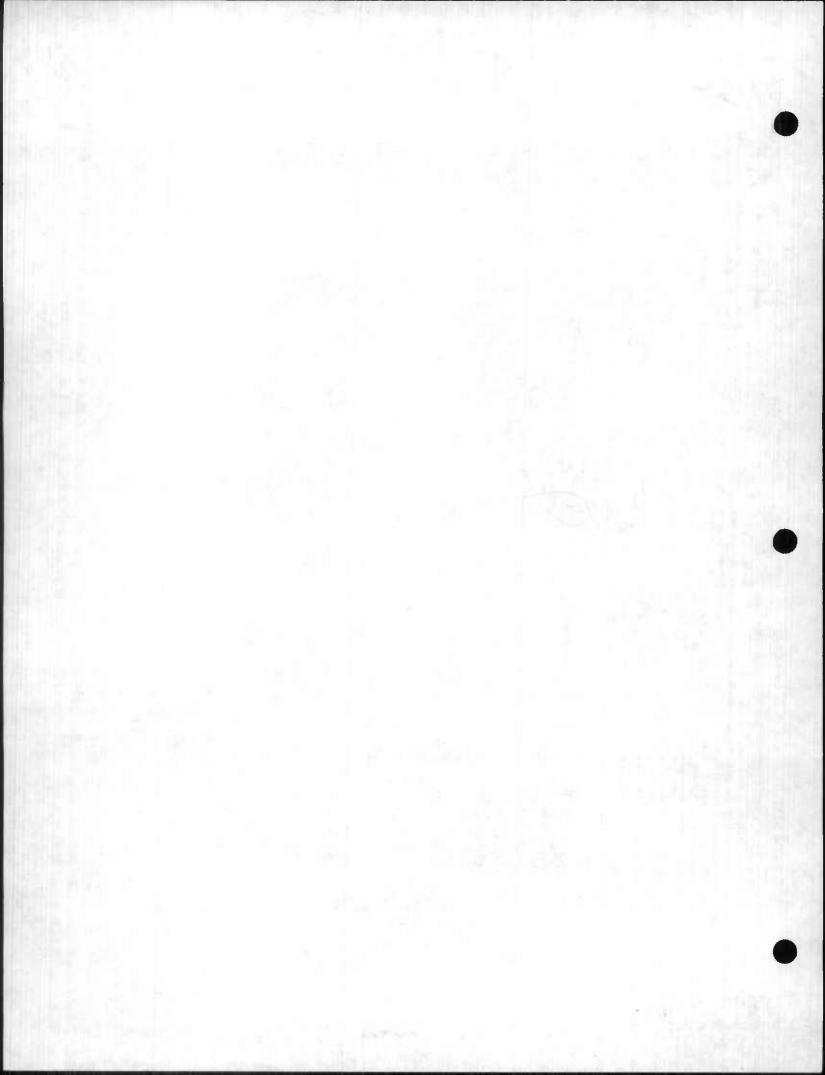
32. Registrar's Signature

nd address of person who completed cause of deeth (Item 23e) (Type, Print)

MU

ORIGINAL

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09861 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day St Year CROVE Month **Physician** 5.50 AC. KOSIE Karch 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Balto HARber Side HomE NUTSING 8. Date of Birth Month Day, Year If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Days 8316 Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumatic event, the Moulcal Expenser mant be nothed at B alto 18 Yes 2□ No Director Md 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21239 Apt 103 U.S. A 6101 LOCKRAVEN death 14. Race - American Indian, 12. Was Decedent Ever In U,S Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) pernit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or ite any finlury or other traumatic event, its Moul all Ensities. 1 Never Married 2 Married 1 Yes 2 No if Yes, Give Year or Dates: Black Hosp 1□ Yes 2 No Specify: à 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Universily HOSO 12 1 18. Mother's Neme (First, Middle, Meiden Surname)

FMMA
Thomps 17. Father's Neme (First, Middle, Last) Thomas Berose 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) De Shields 1620 Trygram Rd Balta · Md · 212 39
Dete 20c. Location - City or Town, State Rachel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State PK artulus mem 3/23/00 artulus me 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Enter the disease, or complications that caused the death. Do no, or heart failure. List only one cause on each line. inter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner physician end the burial-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last thet the death certificate be execu P.O. Box 68760, Due to (or as a consequenca of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by to 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? hes 1 Yes 2 Wo certificate Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of Certification: 24 hours after death. Funeral Director: After 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated.

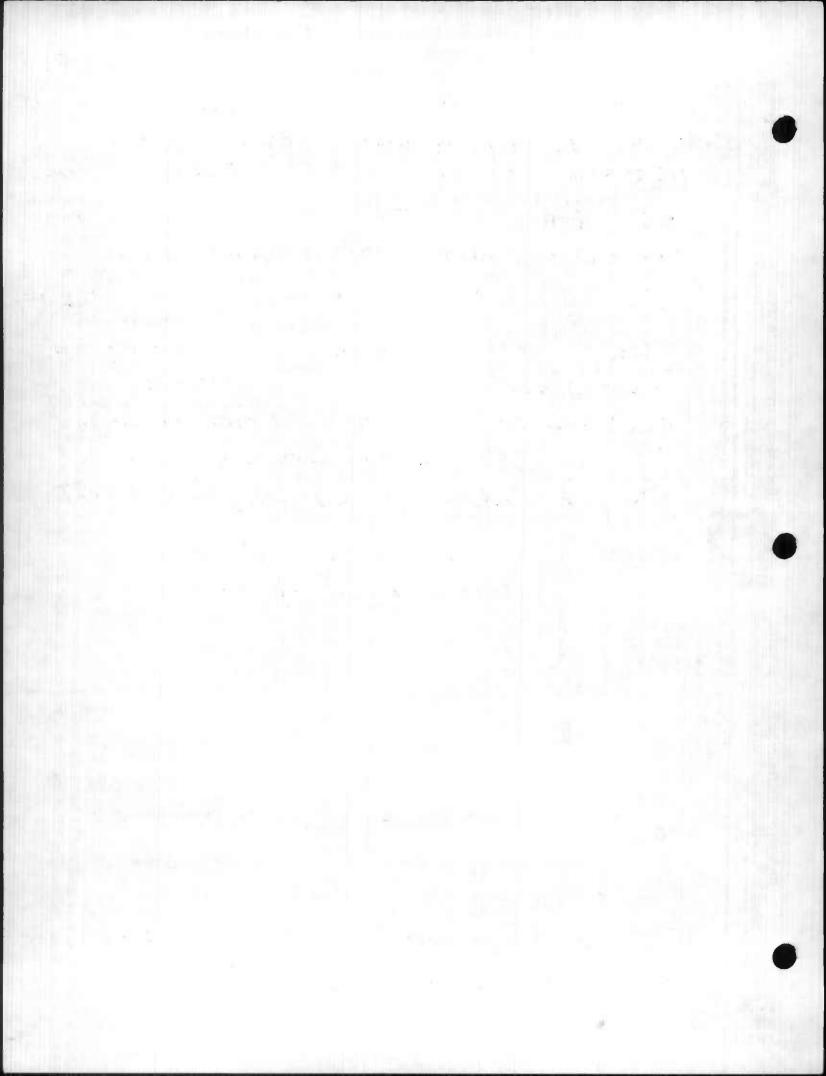
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 943 29d. Date signed (Month, Day Year) 29c. License number 50 66 / 29b. Signature and title of certifier Karch Delidier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIREESH TRIPURAWENT H700 Rayford Rd, Baltimore, Kd - 2(2(4)

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

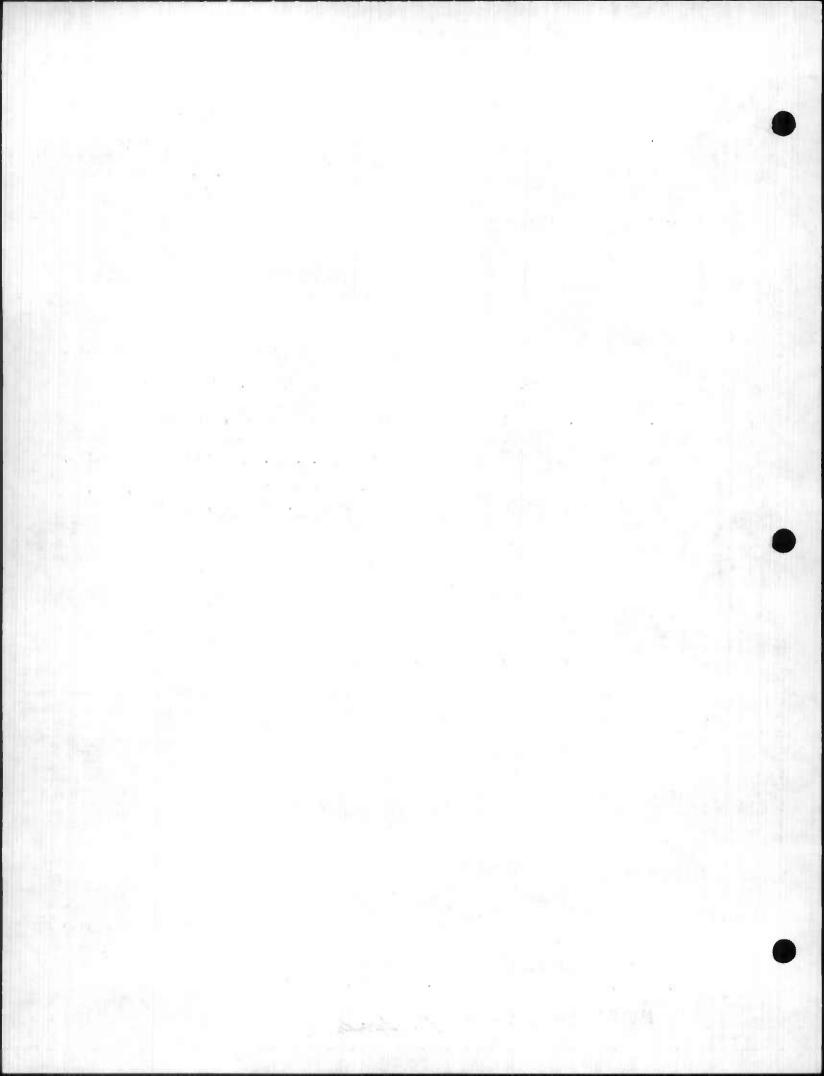
32. Registar's Signature Depende



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State of Maryland / Department of Health and Mental Hygiene 00 09862

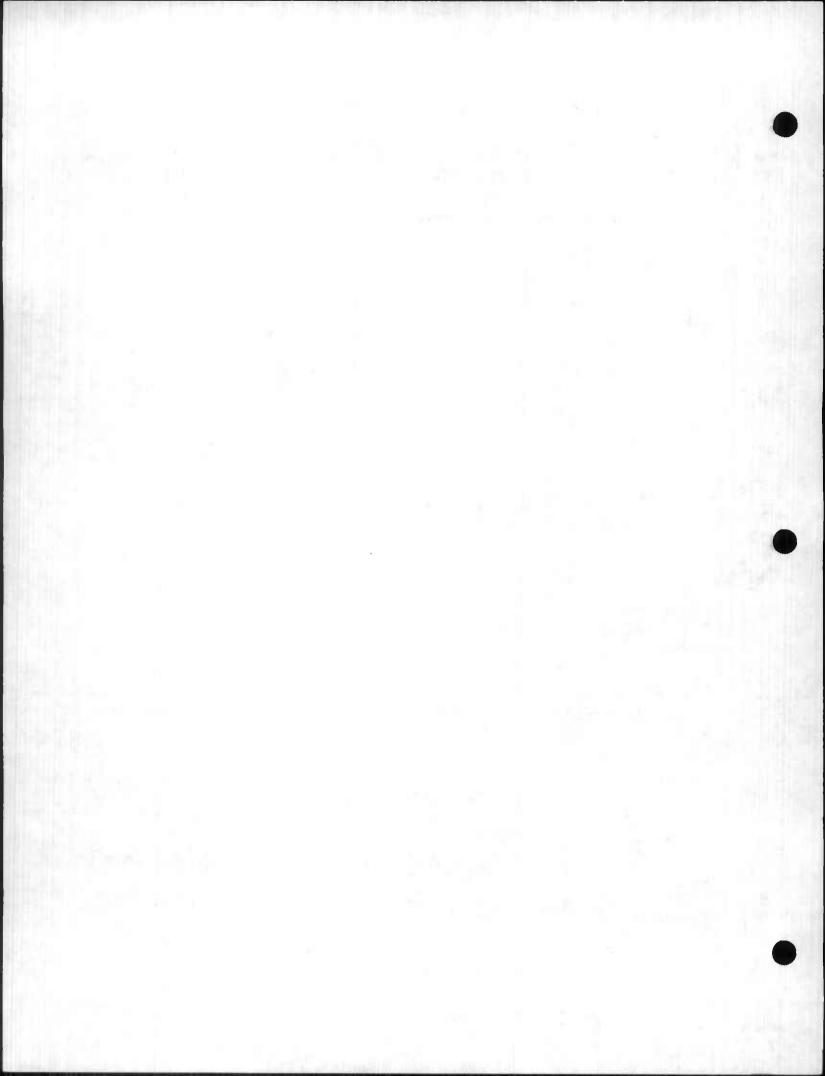
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cal	An Franklin Name (Mant Institution of		neroy		March , or Location of Dear	23, 2000	8:00 A
ner	4a Facility Name (If not Institution, give	a street and number)		4b. City, Town	, or Location of Dea	th 4c. County of i	Death
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	10e. Street and Number 249 Trappe Road		106	. Zip Code 21222	2	10g. Citizen of What United S	
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o Be	t not more carry	(not known)	Gatton			ot known)	
To	19a. Informant's Name/Ralationship (1	Type, Print)		ress (Street and Number of			
	Mrs. Nellie R. G	atton(Wife)	249 Tra	ppe Road Du	ındalk, Ma	aryland 2	1222
	20a. Mathod of Disposition		. Plece of Disposition cematary, cremetory		Data	20c. Location - Cit	y or Town, Stata
	Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Oth			rest V.A.Cen	3/28/20	000 Owing	s Mills, M
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	Han Z. Alar	1000h	7922	Wise Ave.	Dundalk,	Maryland	21222
в	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the de one cause on each line.	aath. Do not antar tha	mode of dying, such as ca	rdiac or raspiratory	errast,	Approximata Intarval Betwee
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edical	that initiated events rasulting in death) Last			1			
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any		d. Turbe	Caux C				1
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Sal Ce	29a. Certifler 1 Certifying Ph	rsician: To the best of my k	nowledge, death occur	red at the time, dete and p	place, and due to the	e cause(s) and mann	er as stated.
edical	(Check only 2 Medical Examone)	liner: On the basis of axamend mennar stated.	nation and/or invastige	ition, in my opinion, deeth	occurred at the tima	, date and place, and	dua to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 00 09863

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/Medical Examiner	4a Facility Neme	(If not institution	, give street and nu	umber)			4b. City, Tov	vn, or Location of						
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uneral	5. Social Security	Number	6. Sex	7. Age (In yrs.	last birthdey,				of Birth	Day Year , 2000 4c. County of Dee MONTGOMER ar) 9. Bir Co O9 14. Race - Am Black, Whi Specify: b. Kind of Business SEAFOOD F den Sumeme) BRESS ity or Town, State, SPRING, I Location - City or ROSEDALE & BROS. ESVILLE, cco use contribute 2 No 3 F utopsy 24b. at end Number or F itel of Souther (Specification) at end Number of F itel of Souther (Specification) at end Number of F itel of Souther (Specification) at end Number of F itel of Souther (Specification) at end Number of F itel of Souther (Specification) at end Number of F itel of	nplaca (Stata or Fore			
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	1 N Burial	2 Cremation	3 Removal from	Stete	cemetery, cre	emetory or other	plece)SEDE	K						
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certificate he rector, page Be Com	7.7								1 ☐ Yes 2 🔀	No '	1 ☐ Yes 2 ☐ No			
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9 0	1 Yes 2	⊠ No	Hospitel: 1	Inpatient 2	ER/Outpatie		Other: 4 Nu	rsing Home 5	Residence 6	Other (Spec	city) DOCTORS C			
After th funeral flon:	27. Manner of De	eath 5 Pendin	28a. Dete	of Injury nth, Day Year)	28b. Time of	of 28c. I	Injury at Work?	28d. Des	scribe how injury	occurred				
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To the Funeral Di completely filled in medical Cel	(Check only one) 29b. Signature at a signature at	Idress of person	who completed cau	use of deeth (Ite	m 23a) (Type	Print) FRRARA	, ,			ARCH:				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09864 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** (ARNER 644 MARCH 4:4587 2000 /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GlenBurnie AmeArunde 1 ariner Health If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 1(X) M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 68 Yrs. Director 216-28-2717 August 31,1931 Pennsylvania Usual Residence of Deceden 10a State 10h County 10c. City, Town or Location 10d. Inside City Limita 28a-f show 1 Yas 2 No Directo Pasadena Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 238 763 202nd Street 21122 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 [∆] Yas 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be Illad within 72 hours ahar ment of Health and Mental Hygiene.
Int. If them 27 is marked other than "natural", or its introduced event, the Medical Examinatory or other traumatic event, the Medical Examinator. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Mechanic Automotive Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Guv Fetzer Garner Hazel Irene Rutter 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Kimble 763 202nd Street, Pasadena, MD 21122 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Steta 4 ☐ Donation 5 ☐ Other (Specify) March 24 Baltimore, MD Metro Crematory, Inc.
| 22. Nama and Address of Facility 21. Signature of Funeral Service License Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in death) RESPIRATORY FAILURE Examiner PNEURONIA Physician/Medical Examiner The law requires that the death certificate be asscuted attending physician and for use as the burlal-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. CEN EBROYASURAN DISEASE 1 Yes 2 No 3 Probably 4 € Unknown signed to by DATE ENTIF 24b. Ware autopsy lindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 200 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cesa referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation Division a after death.
I Director: Af 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by TC Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D-Z2609 4.0 MARCH 23.2000

State Registrar

DHMH 16 Rev 6/95

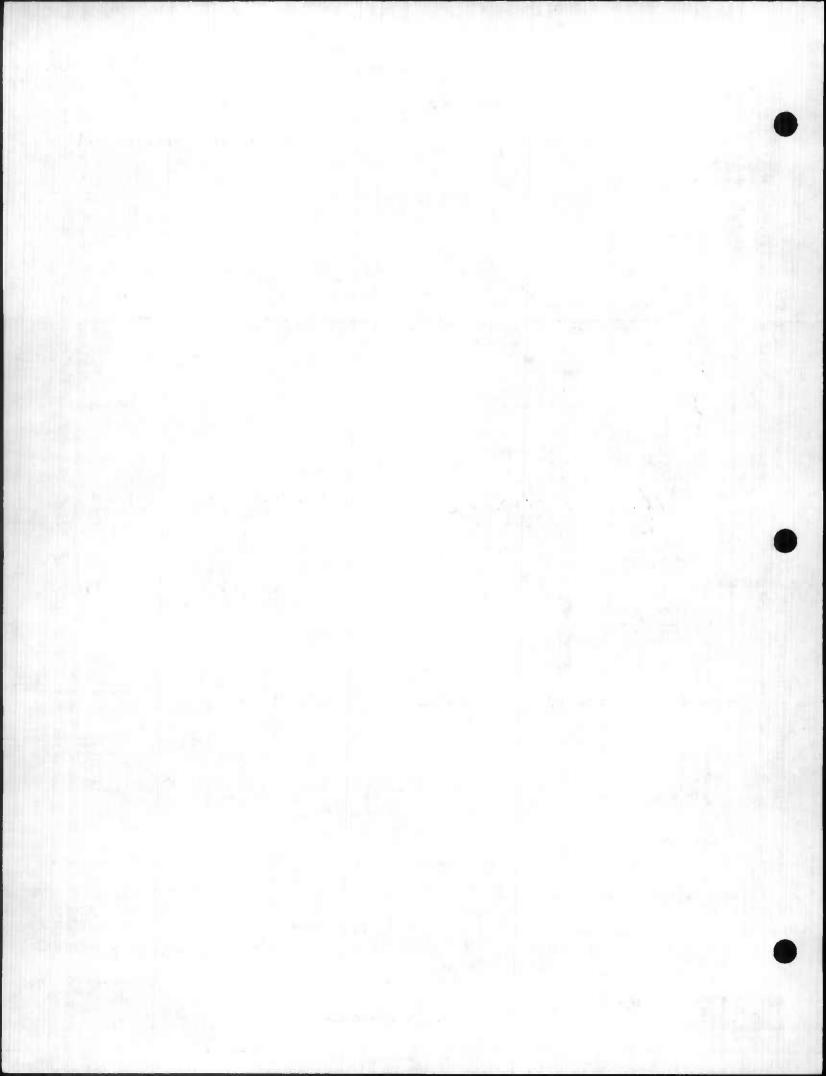
31. Data filed MAR 29.4 -2000

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

RVB & REIDER M.D. 7445

32 Registrar's Signature

FURNACE BRANCH Rd-GLEN BURNETED 21060



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09865 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month 2000 TOMMIE J. HARDY March 19 1637 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 709 Bayberry Road Edgewood Harford If Under 1 Year If Under 24 Hrs. 8. Dete of Birth April 8, 1935 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1 M 2 □ F Vigenia 64 Yrs. 226-44-4582 **Usual Residence of Decedent** 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Bayberry Road 21040 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Bleck, Whita, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1958-60 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Laborer Steel Industry 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Elizabeth Elliott Joe Hardy 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 709 Bayberry Road. Edgewood. MD Elizabeth M. Hardy (Wife) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Ø Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Lutheran Church Cem. 3/24/00 Joppa, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, 21. Signeture of Funerel Service Licensee Buyun C. Uzullus | 610 W. Macrnum Norm, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart leiflure. List only one cause on each line. 610 W. MacPhail Road, Bel Air, MD 21014 Approximate Intervel Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) MYOCARDIAL INFARCTION NONE Due to (or as a consequence of): ARTERY DISEASE 10 TRS COROWARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital or Attanding Physician:

MOSPIE

To the Hospital or Attar within 24 hours after de-To the Funeral Director completely filled in by th

State Registrar

DHMH 16 Rev 6/95

Physician

/Medical

Examiner

Directo

Funeral

Completed

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Funeral

Director

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72 hours after

filed within

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Department of Important: If any Injury or

Physician

/Medical

Examiner

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for use

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After

s after death.

funeral director.

physician a the burial

Pue

Examiner

Physician/Medical

2

Completed

8

Certification: To

edical

29a, Cartifier

(Check only one)

21215-0020

altimore, Maryland

29b. Signature and title of certifier

29c. License number 1) 24740

30HNS

HOPKINS

29d. Date signed (Month, Day, Year) 2000

BALTIMORE

HOSFITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS A 31. Date filed (Month, Day, Year)

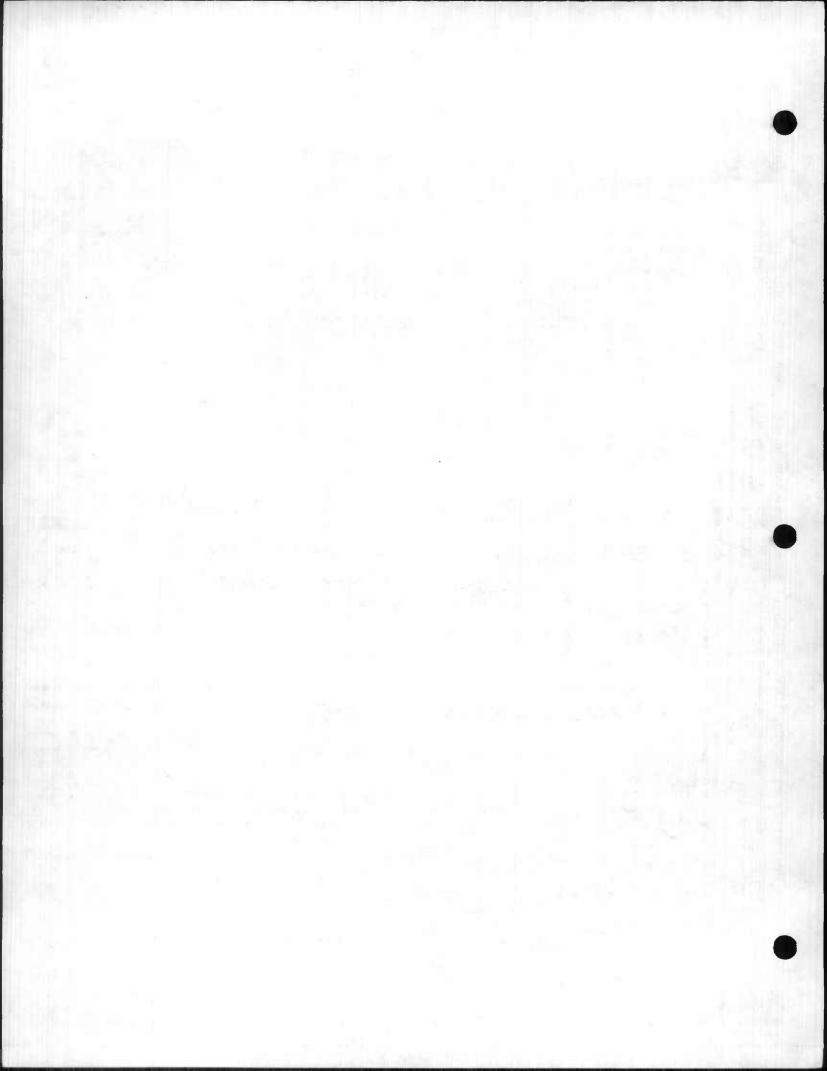
MAR 2 7 2000

TRAILL

32. Registrar's Signeture

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the cause(s) end manner steted.

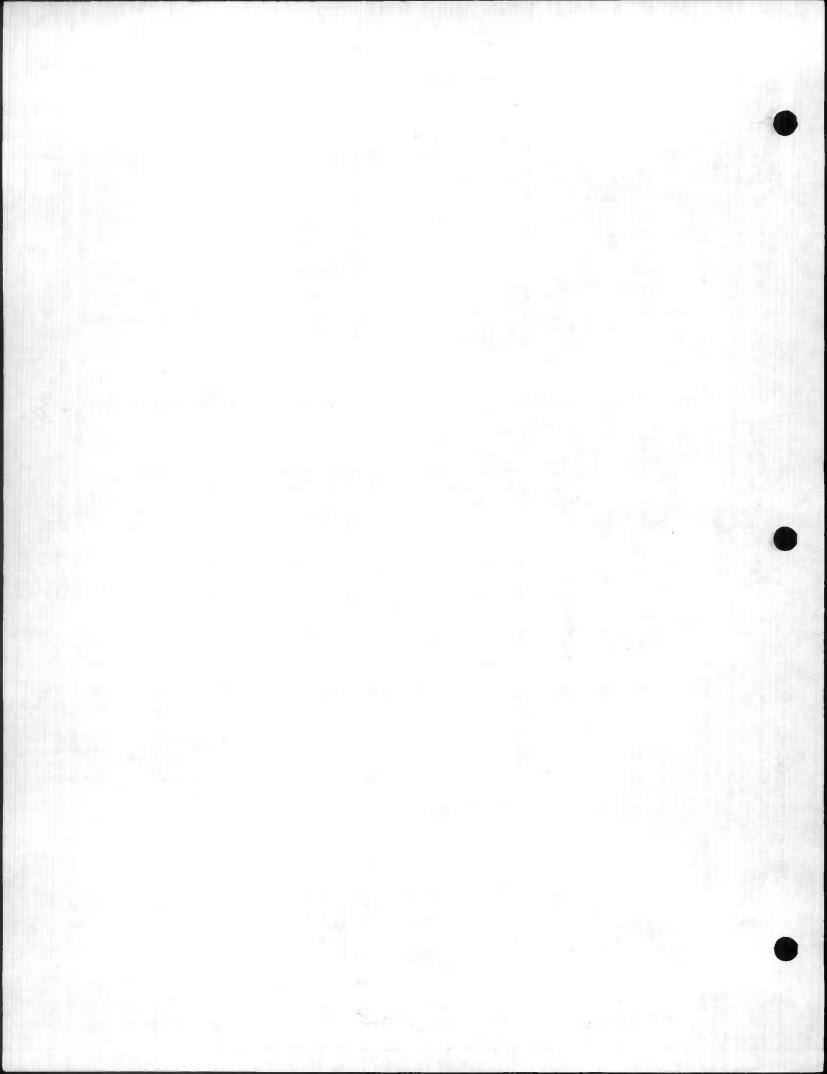


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 09866 Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month March Hawes 21 7000 23:59 leresa /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS Baltimore If Under 24 Hrs. 8. Date of E la Thes Johns If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days 1 M 2 KF Months Hours 48 Yrs. **Director** 219-52-8484 1951 MD May 26, Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 25a-f show 1 Nes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3934 Grantley Road 21215 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒No or thems Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Maritai Status Black, Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Yas, Giva Specify: Black hq 3 ☐ Widowed 4 ☑ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Hospital Elementary/Secondary (0-12) Collega (1-4or 5+) 4 Clerk altimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Pages 1 and 2 should be nent of Health and Mental Catherine E. Williams Ivra Hawes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) nt of Health a : If Item 27 is or other tra 3934 Grantley Road, Baltimore, MD 21215 Catherine E. Hawes-Mother 20b. Place of Disposition (Name of 20a. Method of Disposition Data 20c. Location - City or Town, State cematary, crematory or other place) Mar 28 1 XBuriai 2 Cramation 3 Removal from Stata Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2000 Zion Cemetery 21. Signatura of Funeral Service Licensee 22, Name end Address of Facility Smith & Williams Funeral Home, Clo Baltimore, MD 2818 East Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finet One month liver disease diseasa or condition rasulting in daath) Stage **Examiner** Examiner Ten Genes Hepatitis the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated events resulting in death) Last Due to (or es e consequence of): pue P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) USe as Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by AIPS, pancreatitis Records, þ should be 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No certificate of Vital or Attending Physician: funeral director. 25. Was casa rafarred to medical axaminar? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yas 2□ No Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannag of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Division 1 Maturat 5 Pending after death. 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida To the Hospital of within 24 hours at To the Funeral D completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 March 22, 2000 Medical Doctor 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) Maryland 21287 Michal Melomed Wolfe Baltimore 600 North Street 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar 2000 MAR 2 7

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** HARPER JANIE 03 11:10 km 23 2000 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Homewood Genesis Elder car NA Balto MK If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth Month, Dev. 04-16 **Funeral** Birthplece (State or Foreign Country) Months Devs 259-94-1732 Director 94 GA Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 'natural', or items 23a or 28a-f show 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryla Department of Health end Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show shiplury or other traumatic event, the Medical Expirition must be notified at once. MD NA Baltimore Director 1 XYes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2700 N. Charles Street 21218 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: 11. Maritet Stetus 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: Black XIXWidowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Farmer self-employed 6th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meldan Sumame) Be Unknown Andrew Barksdale Mamie 2 19e. tnforment's Neme/Retetionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21213 Willie MAe Robinson 1839 N. Bond Street Baltimore, Maryland 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State GA. 1 Buriat 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetlon 5 □ Other (Specify) New Ford Bapt. Ch. Cem. 03+31-2000 Danburgh, 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signeture of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue Warren ander 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervet Between Onset end Deeth **Physician** /Medical Immediata Cause (Final disease or condition resulting in deeth) eimen's Examiner Due to (or es a consaguence of). Examiner The lew requires that the death certificate be executed physician end the burial-transit Sequentielly tist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in deeth) Lest Due to (or es e consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es a consequence of) for use as signed by the e Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert It. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 12 beter Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has t irector, page 2 s 1 Yes 2 PINO 1 ☐ Yas 2 ☐ No al or attending Physician: The safter death.
It Director: After this certificate ed in by the funeral director, pa Be 25. Wes casa referred to medical 26. Plece of Deeth (Check only one) Hospitat: Other: 4 Nursing Home 5 Restdence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Menner of Deeth 28e. Deta of tnjury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1- Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Dis complataly filled in edical 29a. Cartifier 1 Certifying Physician: To the best of my knowledga, daeth occurred et the time, dete end place, and due to the cause(s) and mannar es steted. (Check only one) 2 Medical Examinar: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end mennar stated. 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dev. Year) d address of person who completed causa of death (Item 23a) (Type, Print) M. NEOVE MAIN 110 55

DHMH 16 Rev 6/95

State

Registrar

31. Data fited (Month, Day, Year)

MAR 2 7 2000

32. Registrer's Signeture

3845 Bonview Avenue

15. Decedent's Education (Specify only highest grade completed)

William Edward Hewitt, Sr.

William E. Hewitt, III / Son

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

Baltimore Birthplace (State or Foreign Country) July 30, 1934 Baltimore, Md.

22 2,000

4c. County of Death

10d Inside City Limits 1XXYas 2□No

7:45 pm

10f. Zip Code 10g. Citizan of What Country? 21213 United States

2. Date of Death March

> 14. Raca - American Indian, Black, White, etc. White

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

> Conductor Railroad 18. Mothar's Nama (First, Middle, Maiden Sumama)

Adele Tracev

1 Yes 2 No Specify:

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

11707 Kingtop Drive Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State

Woodlawn Cemetery 3/25/2000 22. Name and Address of Facility Michael E. Canapp

5305 Harford Road

LEONARD J. RUCK, INC.

Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Baltimore, MD 21214

Woodlawn, Maryland

3 months

Misa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

12. Was Decedent Ever in U,S. Armed Forces?

1 X Yes 2 No If Yes, Give 1957 - Year or Dates: 1959

College (1-4or 5+)

Approximata Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death)

· Respiratory Failure

can

cell Lung Due to (or as a consequence of)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 Tea 2 No 3 Probably 4 Unknown

29d. Date signed (Month, Day, Year)

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yas 2 No

1 Yas 2 No

25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital:

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dunpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b Time of

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident

6 Could not be 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Dunmers MD 196683 BD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAWANDA Summers 9000 Franklin Square Drive Baltimore, MD 2287

29c. License number

31. Date filed (Month, Day, Year) 32. Registrar'a Signature

State

29b. Signature and title of certifier

MAR 2 7 2000

Registrar

DHMH 16 Ray 6/95

WILLAM

b

'natural', or

Hygiene.

Pages 1 and 2 should be nent of Health and Mental

sportant: If Item 27 by Injury or other to

/Medical

Examine

physician is the buriel

Examiner

Physician/Medical

by

Completed

Be

To

Certification:

edical

Funeral

by

Completed

8

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☑ Divorced

Elementary/Secondary (0-12)

12 17 Father's Name (First Middle Last)

20a. Mathod of Disposition

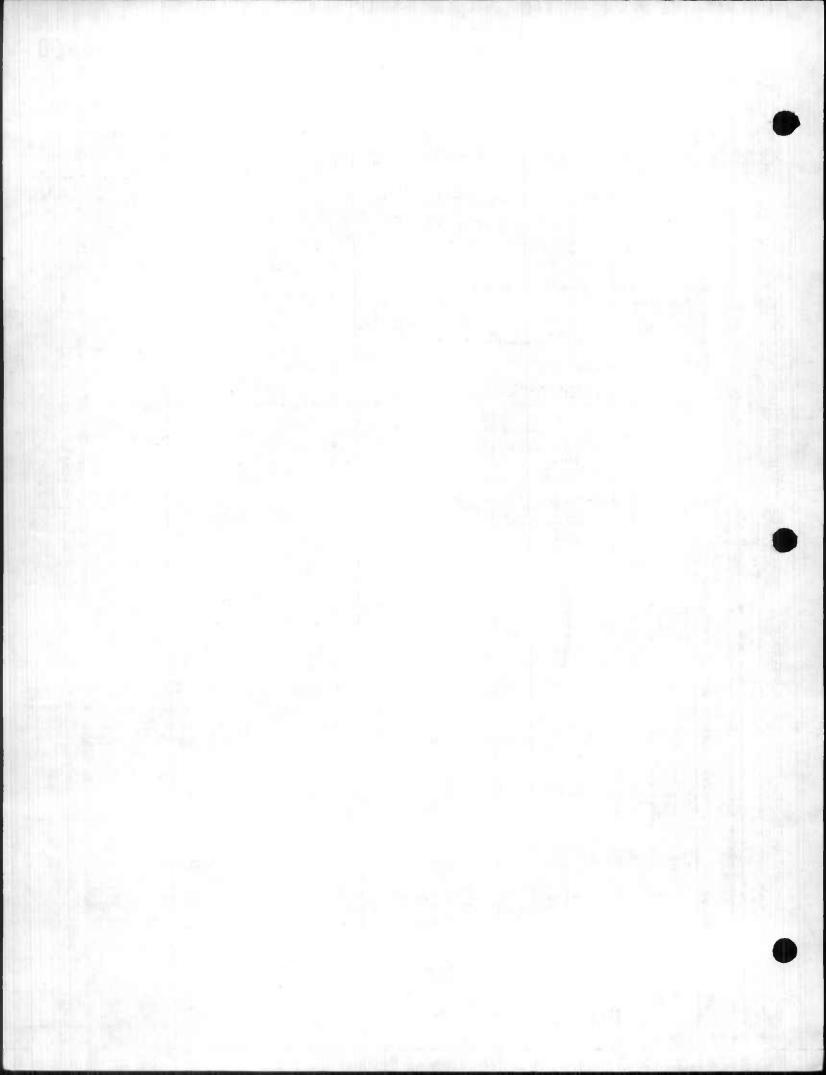
Physician Box 68760. P.O. Records,

The law requires that the death certificate be executed

Division of Vital or Attending Physician: To the Hoepital or within 24 hours aft To the Funeral Dis completely filled in

death.

after deatl Director:



The law requires that the deeth certificate be executed page 2 hee Physician: this funeral After Attending death. the after death

of Vitai

Division

8

Hospital 24 hours

To the Hosp within 24 hou To the Fune completely fi

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were sutopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? VA Yes 2 No 1 Nes 2 No 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Mother (Specify) at SCENE Certification: To 1X Yes 2 No 28a. Date of Injury for (Month, Day Year) 3/16/00 28b. Time of A 28d. Describe how injury occurred Subject drowned 27 Manner of Death 28c. Injury at Work? fourd 9:30 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in creek 28f. Location (Street and Number or Rural Route Number, City or Town, State) Bollingbrook Creek 3 ☐ Suicide 4 ☐ Homicide Trappe, Mi 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

In by

31. Date filed (Month, Day, Year) MAR 2 7 2000

30. Name and address of person who g

ennis

M 32. Registrar's Signature Jeper

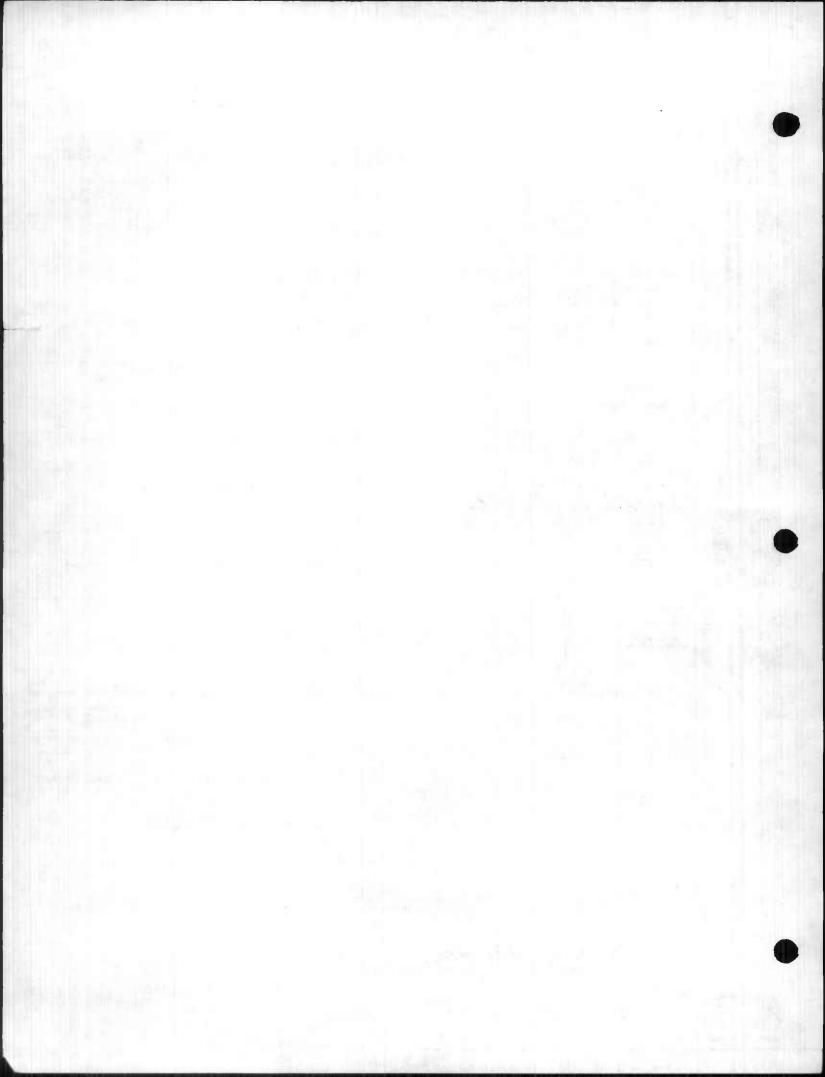
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d cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

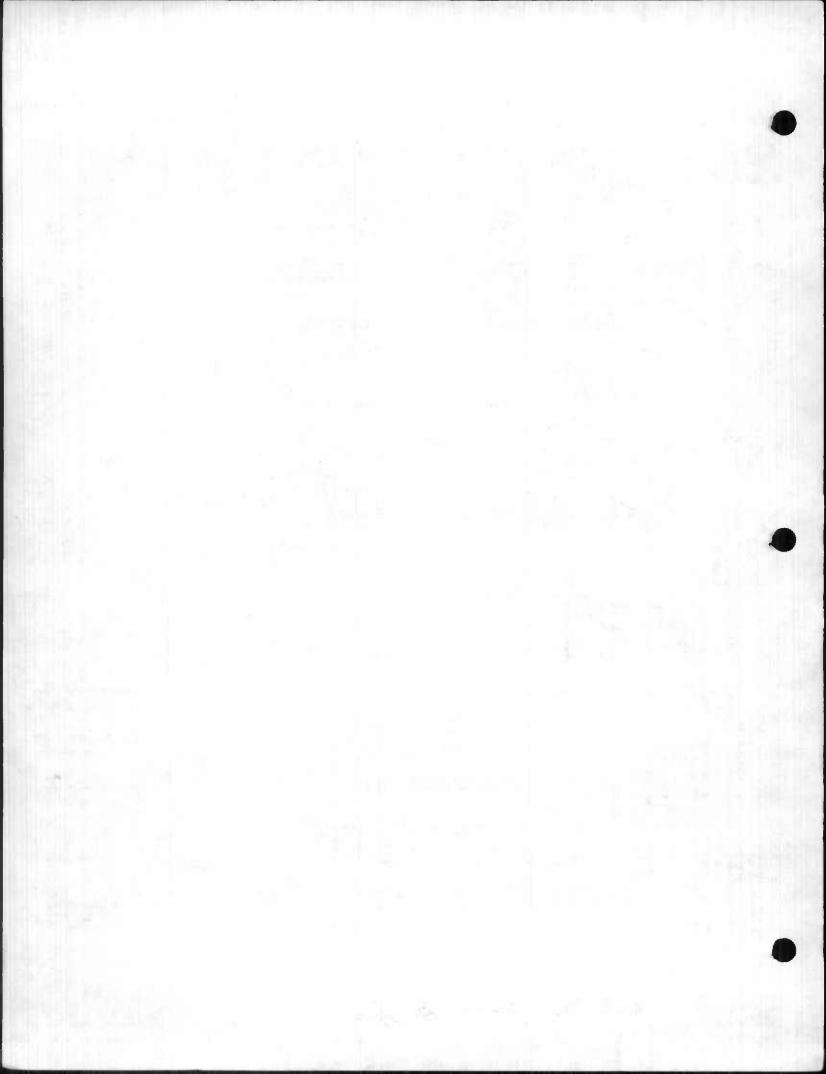
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March 17, 2000



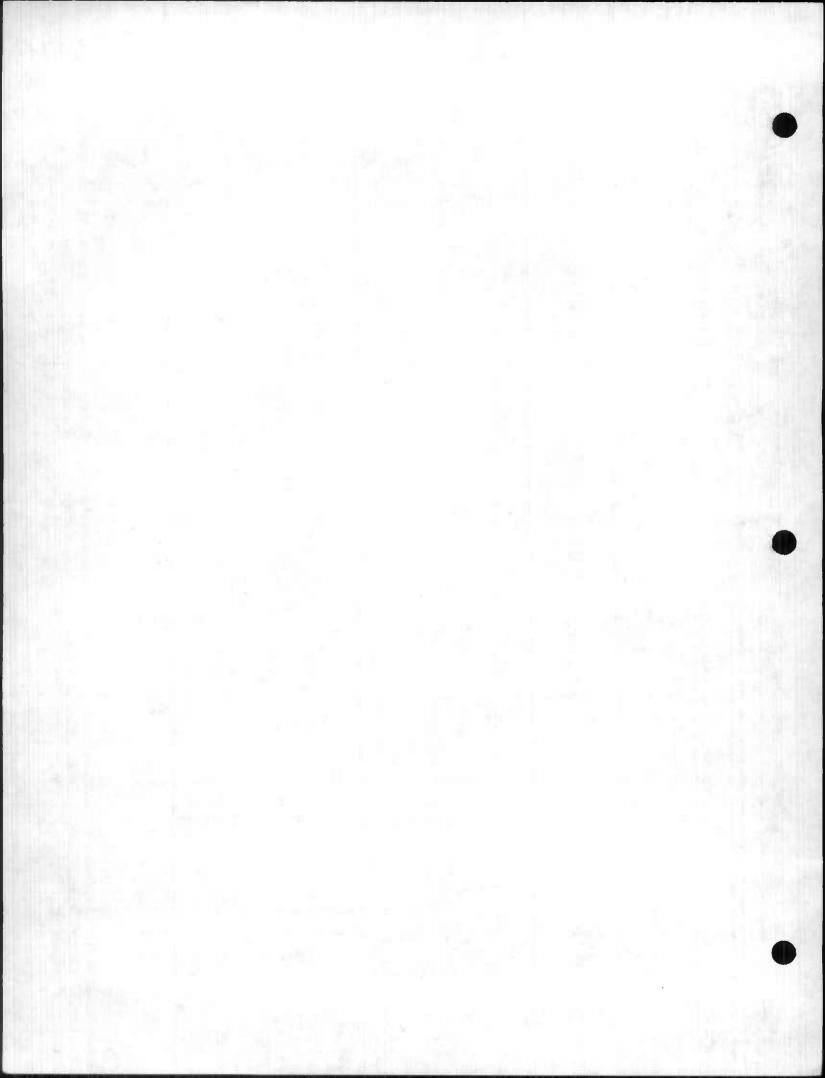
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 9870

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Las		Certificate	e of Death		Reg. No.	
	SUU 9	HICKA			2. Date of Da	1 92/	3. Time of De 10:42
	4 Facility Name (If not instruction of	108 A 0 84 H	Marian	A 4th. Com Town, or	Location of Deat	th 4c. County	of Dealthy
Funeral Director	97 Sopial Security Number 6. St. St. St. St. St. St. St. St. St. St	7. Age (in yrs lest	birthday) If Under	Year II Under 24 flin Days Hours Min	In Date of Bi	78,1918	9. Birthplace (State or Fo
within 72 hours after death with the Maryland ene. Then "neturel", or frems 28s or 28s-1 show the Maddell Engineer must be notified at the Maddell Engineer must be notified at the Maddell Engineer must be notified at the Maddell Engineer Maryland Maryland The Complete of the Maryland Maryla	10a. State 10b. County	10c. Cay (DULTIMU	ne	0		10d. Inside City L 152 Yes 2
ifter death with the Ma if terms 23a or 28a-1 a first must be notified Funeral Director	10e. Street and Number Bell	ma Are	10f. Zip (21212	S	10g. Citigen of V	White Country?
ref. or frame	3 Widowed 4 □ Divorced	12. Wes Decodent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates;	If Yes, speci	ent of Hispanic Origin? (s fy Cuban, Mexican, Puel No Specify:	to Rican, etc.)	Blac Specify	* MERSICAN
So within 72 hours lygions. Nor than "naturel", it, it. In Modes. Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		6a. Decedent's Usual (Give kind of work life. DO NOT use	k done during most of wo	orking	16b. Kind of Bi	usiness/Industry
Popertine in a read a should be listed white Department of Health end Mental Hygiens. Important: If Item 27 Is a marked other than iny Injury or other traumatic avent, the Mana and To Be Comp	17. Father's Name (First, Miodie, Last)	01		UN	16.	, Maiden Suman	
Health end em 27 la m ither traum	199 Informant's Neme/Relationship (7	ype, Print) Guwdan	- 11	(Street and Number or A	ATTIMORE		State, Zip Code)
ant of He art: If item ury or othe	20a. Method of Disposition 1 Deurial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	of Disposition (Name etery, cremetory or off	Houst 1	Date March 28 rox		City or Town, State
Department Important: any Injury	21. Signature of Funeral Service Licen		22 Marris and	Address of Facility &	Ylie	Typie	ral Hn
hysician	23d. Part1. Enter the disease, or comp shock, or heart failure. List only of	ofications that caused the death. It one cause on each line.	Do not enter the mode	of dýing, such es cardie	ac or respiretory (arrest,	Interval Between Onset and Dec
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	Lau (COPD			
leian and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a consequence of):				1
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Z 0.00	TU Yes ZIUNO	Hospitat: 1 Inpatient 2 ER/		Other: 4 Nursing	Home 5 ☐ Res	idence 6 Oth	
To the Hospital or Attanding Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	М	C. Injury at Work? 1 Yes 2 No		how injury occur	ted ber or Rural Route Numbe
ura after ral Direc illed in by	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			City or To	own, State)	
HA		Iner: On the basis of examination and manner stated.					
he Hose in 24 ho he Fune pletely fi			29c.	License number		29d. Date signe	d (Month Day Vone)



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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Leonora Jefferson MARCH 2000 11:30 AM 23 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore, MD Baltimare CITY Union memorial Hospital 2018. Univ PKWY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** 1 M 2 X 86 Yrs. 219-32-0521 Feb. 26, 1914 Director Usual Residence of Decedent the Marviand 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Directo Baltimore Baltimore 28a-f 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? r lams 23s or siner must be à 4417 Hershey Way U.S.A. 21236 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Beautician Pages 1 and 2 should be filed with timent of Health and Mental Hyglen tant; if Nem 27 is marked other th jury or other traumatic event, the 8th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Patrick Moloney Anna May Gentry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Thomas Jefferson 4417 Hershey Way, Baltimore, MD (son) 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or page. New Cathedral Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) 3/27/00 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Buan C. Weller Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. 21236 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Resourator -a. we days Examiner Examiner Coronar Disease lician and burief-transit years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burief Box 68760. Physician/Medical Due to (or as a consequence of): attending pl P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Preumonia Renal Insufficiency Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Arrtic Value Disease, Sepsis 1 Yes 2 X No 1 Yes 2 No Division of Vital Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this funeral di 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 DNatural To the Hospital or Attending within 24 hours effect deeth.

To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Lauren M.D MARCH 23, 2000 sun AT 2438946 - N21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN LAURON MID 201 CAST UNIVERSITY PLLY. BATHWOPE, MD 2018 UNION MEMBRIAL HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

MAR 2 7 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27 Certificate of Death 21-00 WR. Reg. No. Malcolm T. Johnson AMEND ITEMS: #23 PART I. II. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Malcolm T. Johnson, March 21 .2000 4:39 P.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph's Medical Center If Under 1 Year | If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year, 11-18-98 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1€M 2□ F Yrs 218-53-5931 1 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Y⊠Yas 2 No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8 "natural", or items 23e or office! Examiner must be 21224 USA 342 South Robinson Street Funeral 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Biack, White, etc. 11 Marital Status t ☐ Yes 2 No If Yes, Give Yaar or Dates: 1 X Never Married 2 Married 1 Yes 2 No Specify: Saltimore, Maryland 21215-0020 Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Child Child Child Child 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be should be nd Mental is marked Wodarczyk T. Heather Malcolm Johnson, Jr. permit. Pages 1 and 2 sh. Department of Health and Important: If them 27 is me. 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 342 S. Robinson Street Baltimore, MD.21224 Malcolm T. Johnson, Sr. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removei from Stata Voshell Mem. Gardens 03-27-2000 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue Cur wen 23a Part1. Entar tha disaasa, or ofm shock, or heart failure. List only mplications that causad y one cause on each line e death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Onsat and Death **Physician** /Medical Immediate Causa (Final DEHYDRATION disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examine PROBABLE VIRAL GASTROENTERITIS Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In death) Last physician and s the burial-tran Due to (or es a consequence of) De exec 68760 Physician/Medical Dua to (or as a consequence of) 88 attending Box US8 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 signed by t 1 Yes 2 No 3 Probably 4 ☐ Unknown HEPATIC STEATOSIS AND FIBROSIS Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Wes an autopsy performed? page 2 should Completed 1 Yes 2□ No 1 Yas 2 No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1XXYes 2□ No this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: Affer XXNetural 5 Pending Investigation death. 1 Yes 2 No 2 Accident after deatl 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. March 22,2000 30. Name and address of person who complated cause of death (Item 23a) (Type, Print) M.D JACK M. 111 Penn Street, Baltimore, Maryland 21201 31. Data flied (Month, Day, Year)

DHMH 16 Rev 6/95

State

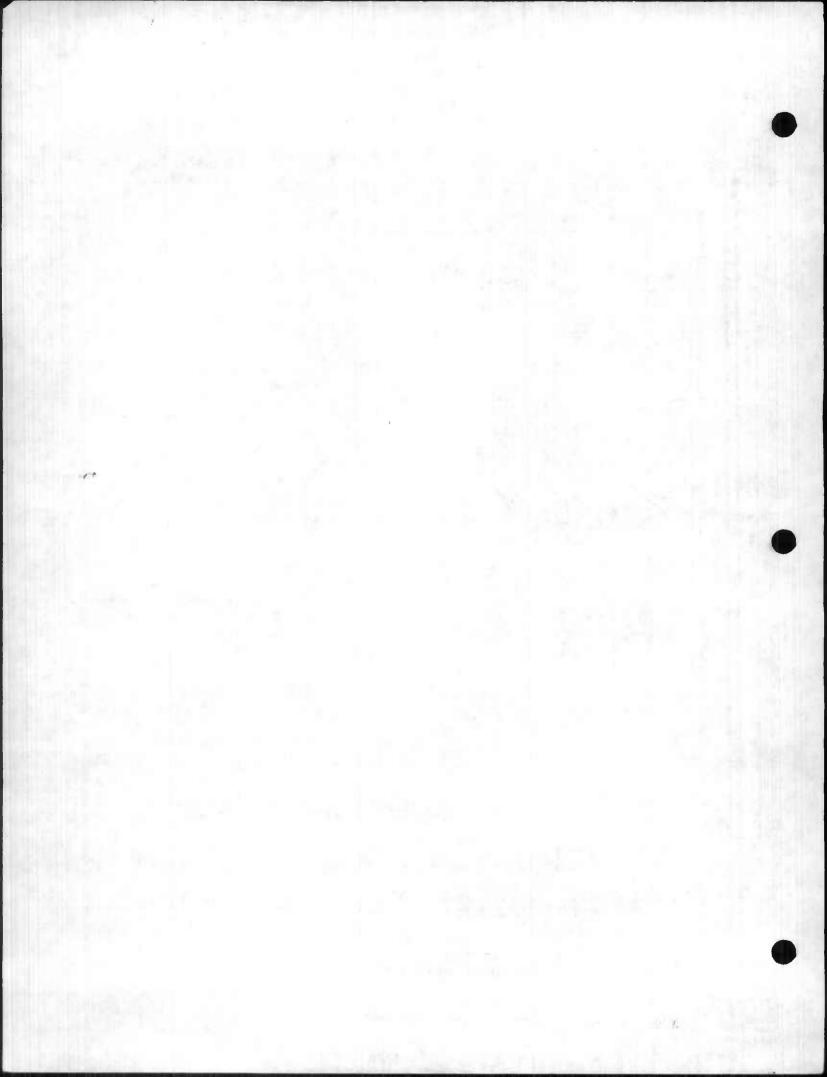
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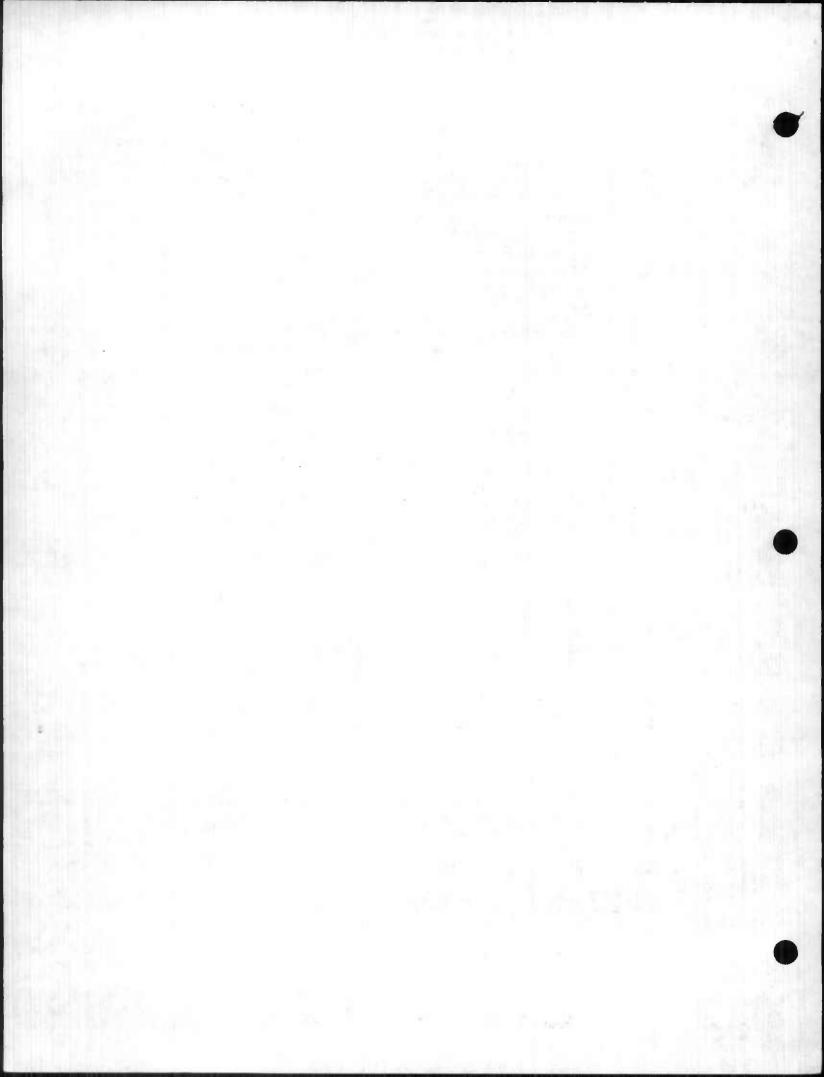
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32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1)

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	Funeral	5. S	ociel Security N	umber	6. Sex	7. /	Age (In yrs.	last birthday)	If Under 1 Year Months Deys	If Under 24 Hrs.				nplece (Stete or Foreign untry)
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21215-0020	ed within 72 ho ygiene. wr then "netur t, the Medical.	E		15. Decedent's Education (Specify only highest grade completed) tery/Secondery (0-12) 4 College (1-4or 5+) 4 BOOKKEEPER 16b. Kind of Business/Indus (Give kind of work done during most of working life. DO NOT use retired) CONSTRUCTION 18. Mother's Neme (First, Middle, Maiden Surneme)										
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	State Registrar	31.	Date filed (Mont	h, Day, Year	MAR 2	32. Regis	strer's Sign		J.	Spark	/			
					PAR SEE 14		- /			11				



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death / 2. Data of Death Day 22 Month Navch 00 Francis D. King 4a Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth N/A Baltimore St. Agnes Hospital If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Oct. 22 1933 9. Birthplace (Stata or Foraign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Days 18 M 2□ F Yrs. 66 219-28-4848 Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Timonium Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 6 Ballycruy Ct. #101 14. Race - American Indian, Black, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yas 2 ☐ No If Yes, Giva Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Korean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Supplies Materials Planner 12 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Alma Turner Clarence King 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 6 Ballycruy Ct. #101 Timonium, Md. 21093 Mrs. Patricia L. King/ Wife 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 3-25-00 Baltimore, Md. 4 ☐ Donation 5 ☐ Othar (Specify) Loudon Park Cemetery 21. Signature of Funaral Service Licens 22. Nama and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 an complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximata Interval Between Onset and Death 2 days Immediata Ceusa (Final Piration diseasa or condition rasulting in death) Yr Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably Dunknown enpheral 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy arction 1 81 non-healing 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only one) axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural Hospitat: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 28a. Data of Injury (Month, Day Year) 5 Pending 1 Yes 2 No

Examiner law requires that the deeth certificate be axecuted physician and s the burlat-transit Frances Kin G. Box 68760, Nislon of Vital Records, P.O. Box 68760, signed by the at d be detached for

Physician

/Medical

Examiner

Funeral

Director

28a-f show

r than "natural", or frams 23a or 28a-f show the Medical Examiner must be notified at

Hyglene.

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other treumatic avent bottes.

Physician

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hours after

Baltimore, Maryland 21215-0020

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Funeral

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Completed

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Certification: To

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after death. Director: / e Hospital or 1 24 hours after Funeral Dire To the Func within 2 To the 1

10/1

State Registrar

31. Date filed (Month, Day, Year) MAR 2 7 ZUUU

29b. Signeture and title of certifier

2 Accident

(Check only one)

3 Suicide 4 Homicide

29a, Certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

32. Registrar's Signature

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

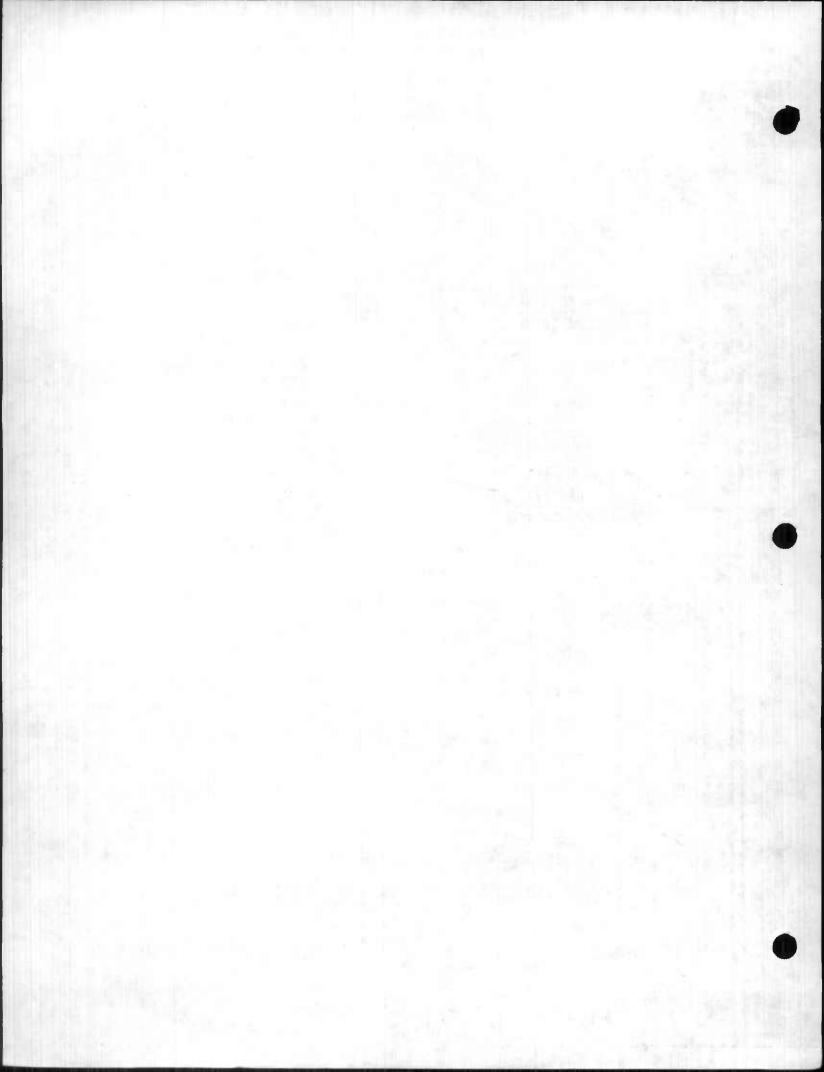
SHARE

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State of Maryland / Department of Health and Mental Hygiene 00 09876

					Ce	rtifica	te of	Death			Reg. No.			
Physician /Medical	1. Decedent's Na	me (First, Middle, L HIRAM	ast)			LEAD	ER			2. Date of De MARCH 2	ath 22, Day 2000	Year	3. Time of D 3:30PM	
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Funeral Director	5. Social Security 216-14-	1687	Sex M 2□ F		7 Yrs.	Months	Days	If Under Hours	Min,	8. Date of Bir (Month, Da JUL - 15	th Year) 5,1922	9. Birthp Coun	iace (State or intry)	
fatow fled.at tor	Usual Residence 10a. State MD	10b. County BALTIM	ORE		SALTIMO						- 10	1	0d. Inside City	
23s or 28s-f st ust be notified rai Director	10e. Street and N 3410 F	umber REDMAN ROA	AD			10f. Zi	p Code	21207			10g. Citizen of U.S.A		ntry?	
ir, or items 23s Examiner must by Funeral		rried 2 Merried	Armed F	2 X No	U,S. 13.	Was Dece If Yes, ape	ecify Cub	en, Mexicar	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		ce - Americ ck, White, y:		
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Department of Health Important: if Item 27 any Injury or other b 2006.		sposition Cremation 3 5 Other (Spec		State						Date 20c. Location - City or Town, State 24/00 RANDALLSTOWN, MD				
	21. Signature Juneral Service Learnee 22. Name and Address of Facility SOL LEVINSON & BROWN ROAD - PIKESVILI										ROS.,	INC.		
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To the Funeral completely filled Medical C	(Check only one) 29b. Signature an	2 Medical Exa	and mer	nner stated.	om 23a) (Type,	7		se number			29d. Date signo	ed (Month,		

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09877 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death March TONY MAZASCHILL O 25 2000 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death ICU FALLSTON GENERAL HOSPITAL FALLSTON HAZFOND 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 1 Ø M 2 ☐ F Birthplace (State or Foreign Country) 235-38-0847 June 5, 1928 West Virginia **Usual Residence of Decedent** 10e State 10b County 10c City Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Harford Joppatown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 233 Kearney Drive 21085 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give Year or Dates: 14. Rece - American Indian 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th grade Sheet Metal Finisher Automotive Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vito Maraschillo Rosie Milam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 Kearney Drive, Ellen V. Maraschillo (Wife) Joppatown. MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1) Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 13/28/00 Middle River. Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 210 21. Signature of Funeral Service Licensee a. Willew Bush 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart laiture. List only one cause on each line. Approximete tnlervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) MYOCARDIAL INFANCTION WIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENSION 24b. Were autopsy lindings available prior to completion of cause of death? DIABETED MELLIUS II. 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28e-f

Berne 25a

al Hygere, d other than "ratural", or In event, the Medical Examin

. Pages 1 and 2 should be fill ment of Health and Mental Hy ant: If them 27 is marked oth lury or other traumatic even

Baltimore, Maryland 21215-0020

Directo

Examiner physician and the burlet-transit Physician/Medical by

Certification: To After this death.

Vital Records, P.O. Box 68760,

Attending Physician:

Maraschillo

101

Completed 8

ie Hospital or Attandit n 24 hours after death. Ne Funeral Director: A plataly filled in by the f To the Hosp within 24 ho To the Fune complately fi

State Registrar DHMH 16 Rev 6/95

25. Was case referred to medicat 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1€ Yes 2□ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 Netural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and menner as steled.

2 Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one)

29b. Signature and title of certified OME 29c. License number OCME

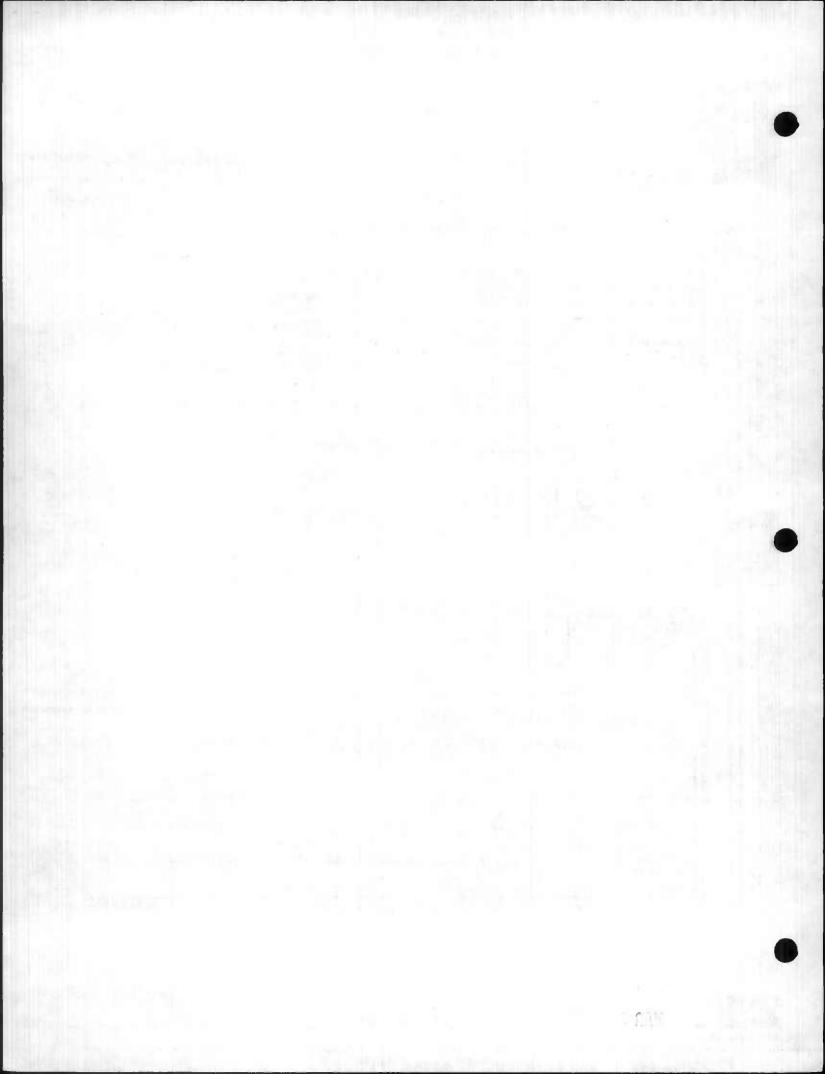
29d. Dete signed (Month, Day, Year) MAZCH 25,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRASHUMD BKLAIN MO 21014 410-879-6564 128 BEZANNO 31. Date filed (Month, Day, Year)

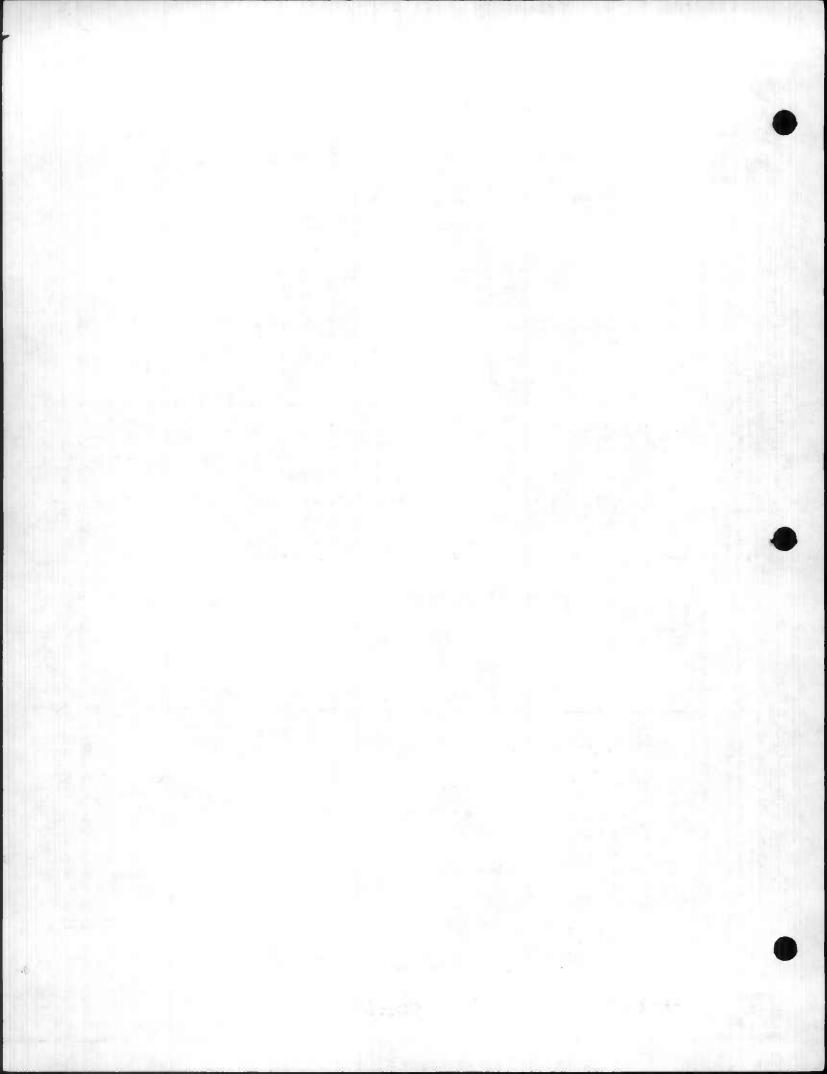
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32. Registrar's Signature oaks



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23a perPHYG781 3/27/2000 EW 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 21, 11:35 Pm WANDA MARRINER JI FeB 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CAIC ELKTON MD. LAU/eLWOOD Lecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** Months 10 M 20F 82 Yrs 195-05-426 Director MICHIGAN **Uauat Residence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director CCCI SING SUN 258-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 21911 U.S.A SUITEY Funeral 14. Rece - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1 Never Merried 2 Merried 1 Yes 2 No 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: WH, Te þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker Pages 1 and 2 should be filed vinent of Health and Mental Hygie ant. If Nem 27 is marked other 1 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STANLEY ZA JAN 19a. Informant's Name/Relationship (Type, Print) ZAJANO LCOKADIJA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Copartment of Health ar-important: if New 27 is any Injury or other trau office. Drive RISING SUN MID 5 TEVENS KONALD SMITH 20b. Place of Disposition (Name of 20a. Method ol Disposition Deta 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 2000 581,Ng FIELD 4 ☐ Donation 5 ☐ Other (Specify) PAUL 21. Signeture of Funeral Service Licensee 22 Name and Address of Facility Home 259E. MAIN St. ELKHOWAR loous Gee HUNERAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart lafture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner HYPERTENSION The law requires that the death certificate be assocuted physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of): Box 68760, Physician/Medicai Due to (or as a consequence of): USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Onknown 1 Yas 2 No Division of Vital Records, by 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2000 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of tnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Netural 2 Accident or Attanding To the Hospital or must within 24 hours after death.
To the Funeral Director: After must be fulled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture end title of certif cause of death (Item 23a) (Type, Frint) 32. Registrat's Monature Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#23a per PhyG781 3/27/2000 EW Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Year Month **Physician** MAE Aggie 14, 2000 Marshall March 16:40 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NIA Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 20 F 239-34-9666 Vrs N.C. Director Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits NA 1PYes 2 No MD BACTO Director or 28s-f 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? USA BRADFORD 57 23a 21213 1637 N. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Merital Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: filed within 72 hours after 1 Neyer Merried 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes 2 1 No Specify Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HOSPITAL Elementery/Secondery (0-12) College (1-4or 5+) NURSES Ald 9RAde 12 NA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 96 Mental 1 CRAWFORD JOHN. MAE BENNET 2 Pages 1 and 2 should 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bepartment of Health a important: if Hem 27 is any injury or other tree BALTO 1523 E. CRAW FORD MAR 57 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 □ Cremetion 3 □ Removel from Stete mp, LANSDOWNE ZION CEMETERY 40 4 ☐ Donetion 5 ☐ Other (Specify) 22, Name and Address of Facility BETTS, FUND 21. Signatura of Funerei Service Licenses BALTO. HOME FUNERA 1129 N. CAROLINE 21213 St 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, about, or heart tellipre. List only one cause on each line. Approximate triterval Between Onset and Death Physician /Medical Immediate Ceuse (Final Aspiration (TERMINAL) disease or condition resulting in death) 3 Hours Examiner Due to (or as a consequence of) Physician/Medical Examiner Esophageal Cancer 2 Months The law requires that the death certificate be executed Sequentietly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. the Due to (or es a consequence of). signed by the at d be detached for Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 No this certificate of Vital Hospital or Attending Physician: director, 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 X Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 XNo Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division After 5 Pending investigation 1 Neturel efter death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, tarm, street, tactory, office building, etc. (Specify) In by 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29e. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

State Registrar

31. Dete filed (Month, Dey, Year) 32. Registraes Signature 5000 MAR 27

Robert K Pelz, MD

30. Name and address of person who comparied cause of deeth (ttem 23a) (Type, Print)

29b. Signature and title of certified

Johns Hopkins Hospital 600 N Wolfe Street Baltimore, MD 21287 outes

29c. License number

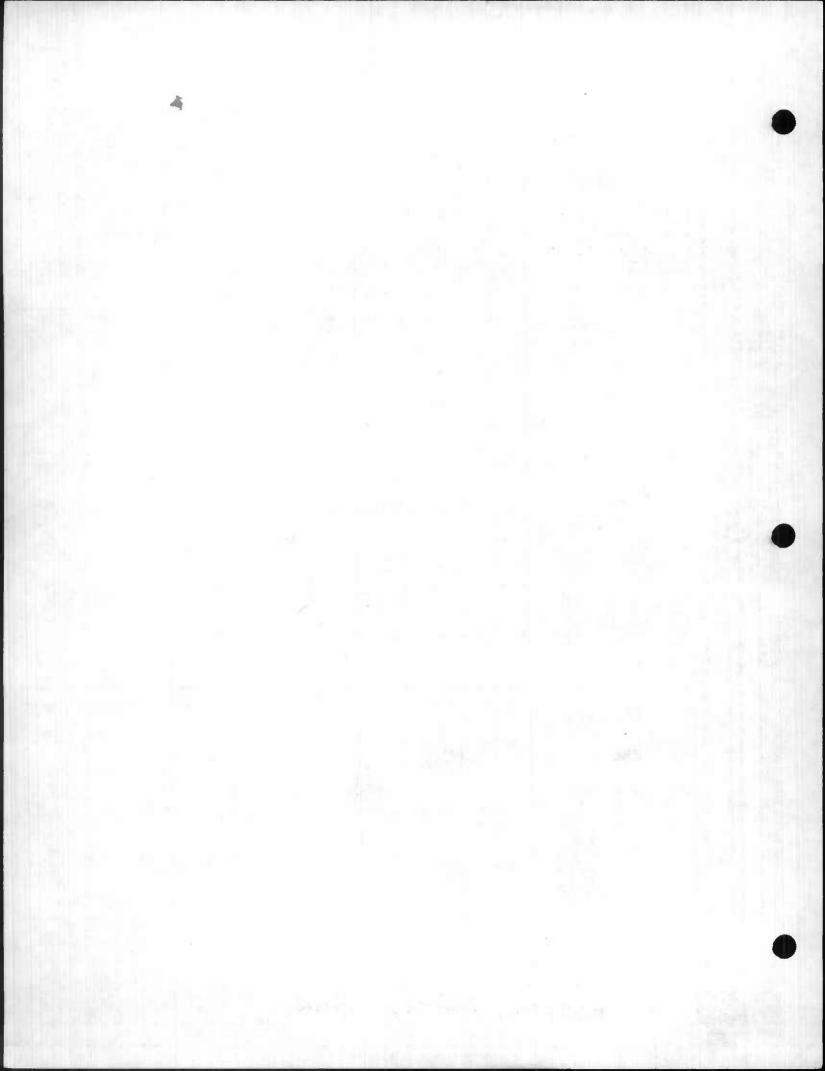
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29d. Dete signed (Month, Day, Year)

2000

March 14

within 2 To the 4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Frank Fortunato Panza March 25, 2000 8:50 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Oct. 17, 1910 9. Birthplaca (Stata or Foraign Country) 5. Social Security Number **Funeral** Months Days Hours 1□XM 2□ F Yrs. 214-03-1698 89 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Abingdon Maryland Harford Directo herre 23s or 28s-f ber must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Cinnamon Tree Drive 21009 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? Raca - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yas 2 1 No If Yes, Give natural, or 1 ☐ Yes 2 (No Specify: Specity: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Grade Machinist Tool & Die Company 18. Mother's Nema (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If flem 27 is marked oth any injury or other traumatic even Be Habbib Panza Guglielmina Passafiore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mrs. Angelina G. Panza 104 Cinnamon Tree Drive, Abingdon, MD 21009 (wife) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☑ Burial 2 ☐ Cremation ☐ Removal from Stata 4 ☐ Conation 5 ☐ Other (Section) Most Holy Redeemer Cem. 3/28/00 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22, Nama and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on sech line. Approximata Intarval Between Onset and Death Physician /Medical Immediata Cause (Finel UROSEPSIS diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ician and buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Due to (or as a consequence of): signed by the at d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Aspiration Preumonia þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Dementia. 1 Yas 2 No 1 □ Yas 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only ona) Hospital: 1 Inpatient 2 SERVOutpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 (DNatural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) ie Hoepital or Attain 24 hours after der Ne Funeral Directo pletely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 135012 March 26, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Attending Physician:

Panza

Baitimore, Maryland 21215-0020

DHMH 16 Ray 6/95

J. Kevinlynch mo

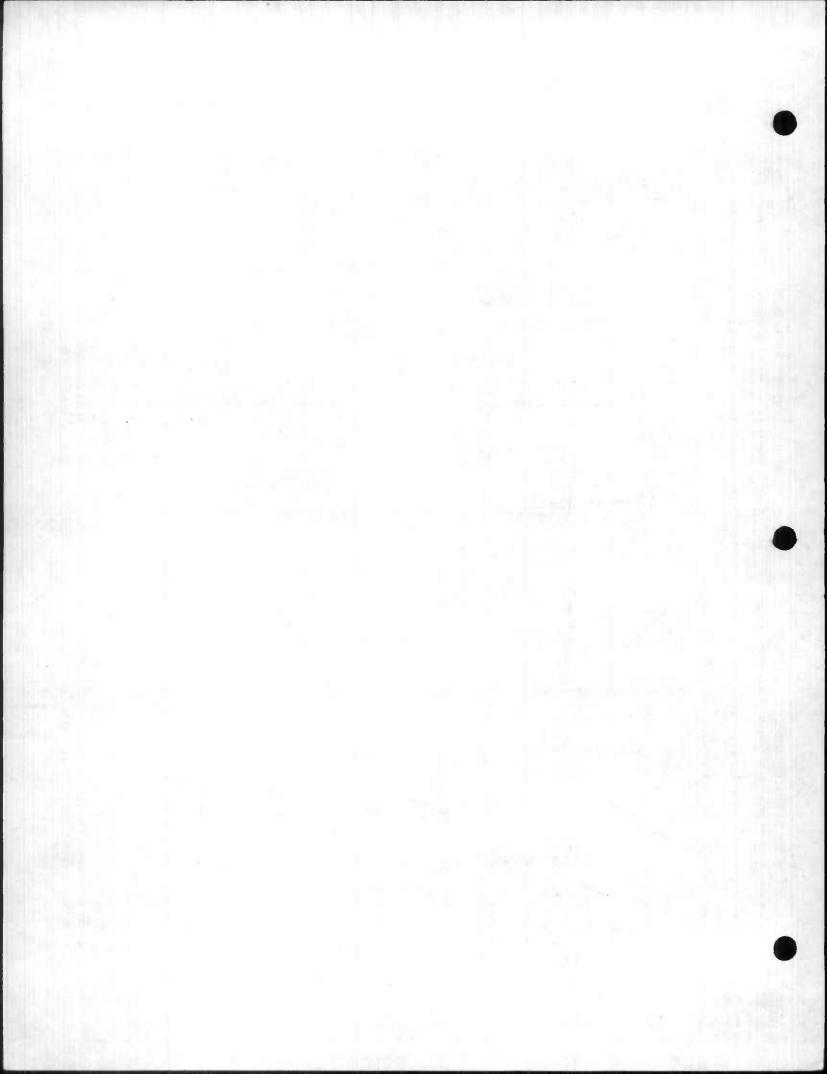
31. Data filed (Month, Day, Year)

32. Registrar's Signature

Sparks

2 North Ave.

Bel Air, Md. 21014.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #12 PER FH G781 3/28/2000 AH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Talmadge Patrick March 21, 2000 16:05 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3511 Reisterstown Road Baltimore If Under 1 Year 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 12-09-22 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1 M 2 □ F Yrs. NC Director 242-28-0969 Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD Director NA 288-1 Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b 3511 Reisterstown Road 238 21215 Funeral USA 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 17 Yes 25 No If Yes, Give Year or Dates: 1 X Never Merried 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Co. Steelside 8th Grade Maryland 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Pages 1 and 2 should be former of Health and Mental Hant: If New 27 is marked officiary or other traumatic even 89 Patrick, Sr. Talmadge Nola Wilkes 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD • 21201 19e. Informant's Name/Raletionship (Type, Print) Blondell Johnson 1027 N. Cathedral Street Apt.J Baltimore, altimore, 20b. Plece of Disposition (Name of 20e Mathod of Disposition 20c. Location - City or Town, Steta Date cemetery, cremetory or other piece) DBurial 2 Cremation 3 Removel from State Baltimore Nat'l Cem. 03-28-2000 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset end Deeth **Physician** tmmediate Cause (Final disease or condition resulting in death) Hypertensive Atherosclerotic Cardiovascular Disease Examiner Due to (or as a consequence of): The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-trar Box 68760, physician Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown Multi-infarct dementia þ 24b. Wara autopsy tindings eveilable prior to completion of causa of death? 24a. Wes en autopsy performed? Completed Peen 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☑ No Division of Vital funeral director, Be 25. Was case referred to medical examinar? 26. Place of Death (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5X Residence 8 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury et Work? 5 Pending investigation Attending 1 Naturel i or Attending after deeth.

Director: Af 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide ni belli 24 hours Funeral 1 Notertifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. Medical 29a. Certifier To the Hour within 24 hor To the Functional Complete y (Check only one)

State Registrar

30. Name end address of person who completed causa of death (Item 23a) (Type, Print)

Dorothy Snow, 31. Dete filed (Month, Day, Year) 10 N. Greene Street, Baltimore, MD M.D.

MAR 2 7 2000

29b. Signature and title of contilion

32. Registrar's Sjgnature ones

DHMH 16 Rev 6/95

29c. License number

29d, Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1248 pm EDWARD MARCH 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore City N/A Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 14 1921 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 15 M 2□ F 78 Yrs. 213-12-2037 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Lutherville 1 Yes 2 No Md. Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 "natural", or items 23a USA 21093 1211 Malbay Dr. Funeral filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 ▼Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4or 5+) Elementary/Secondary (0-12) Engineer Industrial 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be fits Department of Health end Mental IN Important: If them 27 is marked oth any injury or other treumatic even DARA. Be Edward Pfaff Carrie Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Pfaff/ Wife 1211 Malbay Dr. Lutherville, Md. 21093 20b. Place of Disposition (Name of cometery, crematory or other place)

Dulaney Valley Mem Gdns 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burlat 2 ☐ Cremation 3 ☐ Removat from State 3-27-00 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Limit 23a. Parl 1. Enter the distriction of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEDSIS WCEK Examiner Due to (or as a consequence of): Physician/Medical Examiner ACUTE RENAL FAILURE The law requires that the death certificate be executed been signed by the attending physician end ahould be detached for use as the bunal-tran-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that inflated events resulting in death) Last Due to (or as e consequenca ot): Box 68760, ARRHOSIS DUE TO HEDATITIS Due to (or es e consequenca of) MONTH 4-RISTSRAL HOMATOMA P.0. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 □ Unknown STATUS POST CRANIOTOMY, DIABETIES, CONONAL Division of Vital Records, P 24b. Wera autopsy findings available prior to completion of cause ot death? Completed 24a. Was an autopsy performed? page 2 ahould ARTERY DISEASE, PROSTATE CANCER BLADDIOR 1 Yes 28 No 1 Yes 2 No After this certificate CANCER Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 3€ No Impatient 2 ER/Outpatient 3 DOA 2 cours after death.
nerel Director: After this c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending 5 Panding investigation Vatural 1 Yes 2 No 2 Accident 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it DECertifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mianna

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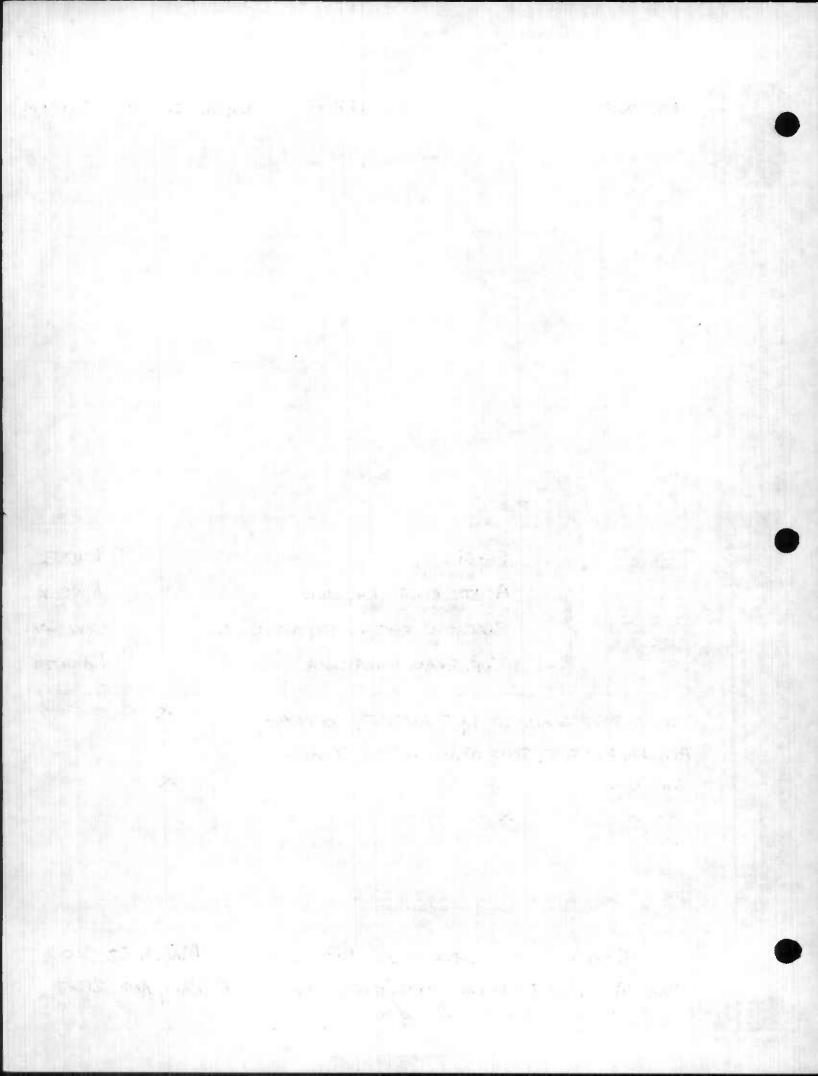
Registrar

MAR 2 7 2000

JUYANNA JUNG 31. Date filed (Month, Day, Year)

600 NORTH WOLFE STREET 32. Registrar's Signature

BALTIMORE MARYLAND



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

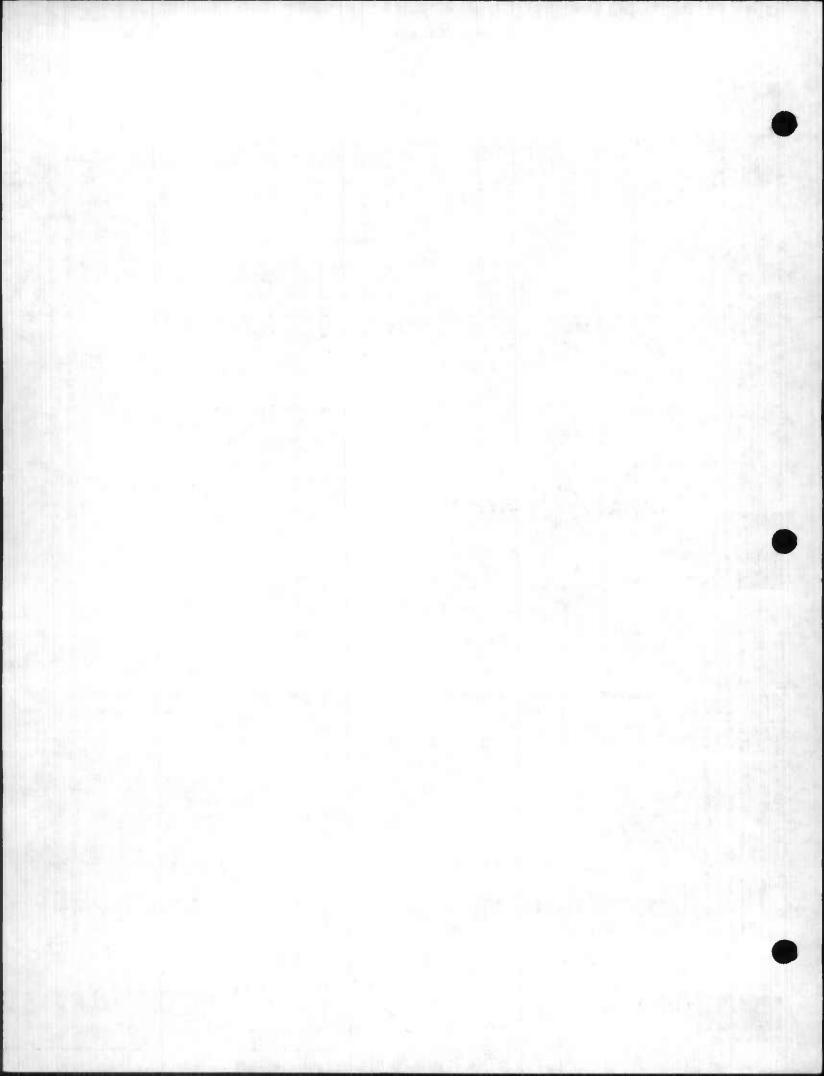
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				Cer	Tillca	te or i	Deain			Reg. No.			200			
1. Decedent's Name (Fin									2. Date of I Month	Day		189	Time of Death			
RICHARD		G.		Pi	AYNE				March		2000		8:40 P.			
4a Facility Name (If not	institution, give	street and num	ber)			4	4b. City, To	own, or Lo	ocation of De	ath 4c.	County of	Death				
Glade Val	ley Nur	sing Ho	me				Walke				Frederick					
5. Social Security Number	- W	M 2DF	7. Age (In yrs.	. last birthday)	If Unde Months	r 1 Year Days	If Under Hours	Min.	8. Date of I	Birth Day, Year)	9	Birthplace	(State or Foreig			
264-74-5623	3	IM 2DF	55	Yrs.					July	15, 1	944	44 unkr				
Usual Residence of Dec		10c. City, Town or Location										landa	- 14 @b 41 3			
	o. County		100. CI													
MD 10e. Street and Number 56 W. Frede 11. Marital Status 12 Never Married	Frederi	ck		Walke	rsvíl	Lle							I□Yes 2XN			
10e. Street and Number					10f. Zij	p Code	1700			10g. Citiz		at Country?				
56 W. Frede	rick St	reet				2	21793				USA					
11. Marital Status		12. Was Dece	dent Ever in L	J,S. 13. \	Wes Dece	edent of H	ispenic Or	rigin? (Sp	ecify Yes or Rican, etc.)	No-		Americen II White, etc.	ndian,			
1 Never Married	2 Married	Armed For 1 Tes If Yes, Give	241 No		1 □ Yes				, , , , , , , , , , , , , , , , , , , ,							
3 Widowed 4 🗆	Divorced	Year or Da	tes:		103	-K-140	Ороспу				Specify.	white				
15.	Decedent's Edu	cation		16a. Deced	dent's Usu	al Occup	ation	et of work	ina	16b. Kii	nd of Busin	ness/Industr	у			
		College (1- unknow	4or 5+)	life. L			during mos	st or work	mg							
Elementery/Secondary UNKNOWN	, (,	unknow	ם י		unk	nown						unkno	wn			
15. (Specify or Elementery/Secondary UNKNOWN 17. Father's Neme (First, unknown	t, Middle, Last)			Name of the last			18. Moth		e (First, Midd	de, Maiden	Sumame)					
unknown								un	known							
19e. Informent's Neme/F	Reletionship (Ty	pe, Print)		19b. Mailir	ng Addres	s (Street	and Numb	er or Run	al Route Nur	nber, City or	Town, St	ate, Zip Cod	(e)			
Glade Valle	v Nursi	ngHome							et Wa				21793			
20a. Method of Disposition			20b.	Placa of Dispo	sition (Ne	me of		3010	Date	1		ty or Town,				
1 Burial 2 Cre			tete	cemetery, crem	netory or	other plac	00)	1								
4 Donation 5 🛚				00	h Alama a	and Andrea	on of Facil	in.			71 . 4	-				
21. Signature of Runral	ald Soll	Vade// D	irecto						d 655	W. Ba	altım	ore S	treet			
MATINA	11-11	1/100	en				, MD	212					9-12-13			
Ja. Part 1. Enter the dis	sease, or compli	cations that cane cause on ea	used the dea	th. Do not ent	er the mo	de of dyin	ng, such as	scerdlac	or respiratory	y arrest,		App	oroximata erval Between			
V		10		()								On	set and Death			
Immediate Cause (Final disease or condition	ı	X	ma	- Ca	10	1)						5	nintle			
resulting in death)		Y	Due to (or as e consec	uence of)):						1	, 00 , -1 ,			
		-	()													
Sequentially that are the			Due to /	or es e conseq	menca on	h:						1				
Sequentially list condition if any, leeding to immed cause. Enter Underlying Cause (Disease or Injury	diate		D4010 (00 0 VVII30Q	Jones Ol)							1				
	y C		Duesni	01.00.0.00	110000 -0											
resulting in death) Last			DO 600	or es e conseq	uerice of):											
		1														
Part II. Other significant	t conditions con	tributing to de	ath but not res	sulting In the u	nderlying	cause giv	en in Part	1.	23b. D				cause of deat			
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									61 11			Odb Mass	autopsy findings			
									248. W	as en autop erformed?	osy	availat	eutopsy finding: ble prior to etion of cause			
												of deal	h?			
									1	□ Yes 2	No	1 🗆 Ye	s 2 No			
25. Was case referred to	o medical						26. Pled	e of Deet	th (Check on	ly one)						
examiner?	F	lospitel:	patient 2	ER/Outpatier	nt 3□ D	OA Oth	er: 42N	ursing Ho	ome 5 R	esidence (6 Other	(Specify)				
1 Yes 2 No		28a. Date o	f Injury	28b. Time of		28c. Injur Wor			28d. Descrit							
1 Netural 5 [2 ☐ Accident	Pending investigation	(Monti	, Day Year)	Injury	М	1 [rk? Yes 2□] No								
3 Suicide 6	Could not be	28e. Piace	of fnjurv - At h	nome, farm, str	eet, facto	ry, office						or Rural Ro	ute Number,			
3 Suicide 4 ☐ Homicide 3 Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 3 Suicide 4 ☐ Homicide 5 ☐ Could not be determined 5 ☐ C																
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(Check only 2		ner: On the ba	sis of examina													
one)	40000	and menn	er steted.		1 00	N. 12				L god Dat	a alamad .	Milanth Day	Venal			
29b. Signeture end title of gertifier 29c. License number 29d. Date signed (Mont										(Montin, Day	, Year)					
MARCH								14	200							
· 611	A				1 2	Name and address of person who completed ceuse of death (Item 23a) (Type, Print)										
A Name and parties o	person who co	mpleted ceuse	of death (Ite	m 23a) (Type,	Print)	11	0 >	10	A, 9	1	2	1 40				
30 Name and parests	person who co	mpleted ceuse	of death (Ite	m 23a) (Type,	Print)	YAI	16	FR	20	M	21-	702	-			

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) 3 Time of Death MARCH 19 Day 2000 Year **Physician** 10:45 PM CLARENCE PLUMMER /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner JOSEPH RITCHIE HOSPICE BALTIMORE If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) Birthpleca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Hours 1X M 2□ F 68 Yrs. 227-38-1643 Director Oct 9, 1931 unknown Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Insida City Limita 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examiner mant be notified at MD N/A 1 Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21216 1525 N. Ellamont Street USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 2 should be filled within 72 hours after and Mental Hygiene. Is marked other than "naturel", or its 1 Yes 2 No
If Yas, Give
Year or Dates: unknown 1 ☐ Never Married 2 X Married Specify: black Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) unknown Elementery/Secondary (0-12) unknown unknown 17. Fether'e Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown unknown 19a. informant'a Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 st Department of Health and Important: if Item 27 ia m any Injury or other traun once. 1525 N. Ellamont Street Baltimore, MD Evelyn Plummer/spouse 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) in State in state ²² Neme and Address of Fecility State Anatomy Board 655 W. Baltimore Street Funeral Servi Ronald 21201 Baltimore, MD PALLIMOTE, MD 21201

The disease or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediata Causa (Final disease or condition rasulting in daath) Pharyngeal consequence of): years Examiner Examiner Squamous carcinoma year physician and s the burial-transit Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Causa (Disaasa or Injury that initiated evants rasuiting in daeth) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): esn Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No SProbably 4 Unknown Hypertension by -larene Plumer 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed Diagetes cartificata hes COPD 1 Yes 25No 25. Was case raferred to medical axaminar? 28. Placa of Deeth (Check only one) Be Right Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No hospice 27. Mannar of Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Natural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accident after death 6 Could not be detarmined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida To the Hospital of within 24 hours at To the Funeral D 1 Sertifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the causa(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the causa(s) end manner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) M. O. 013006 30. Neme end eddress of person who complated cause of death (Itam 23a) (Type, Print)

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Registrar

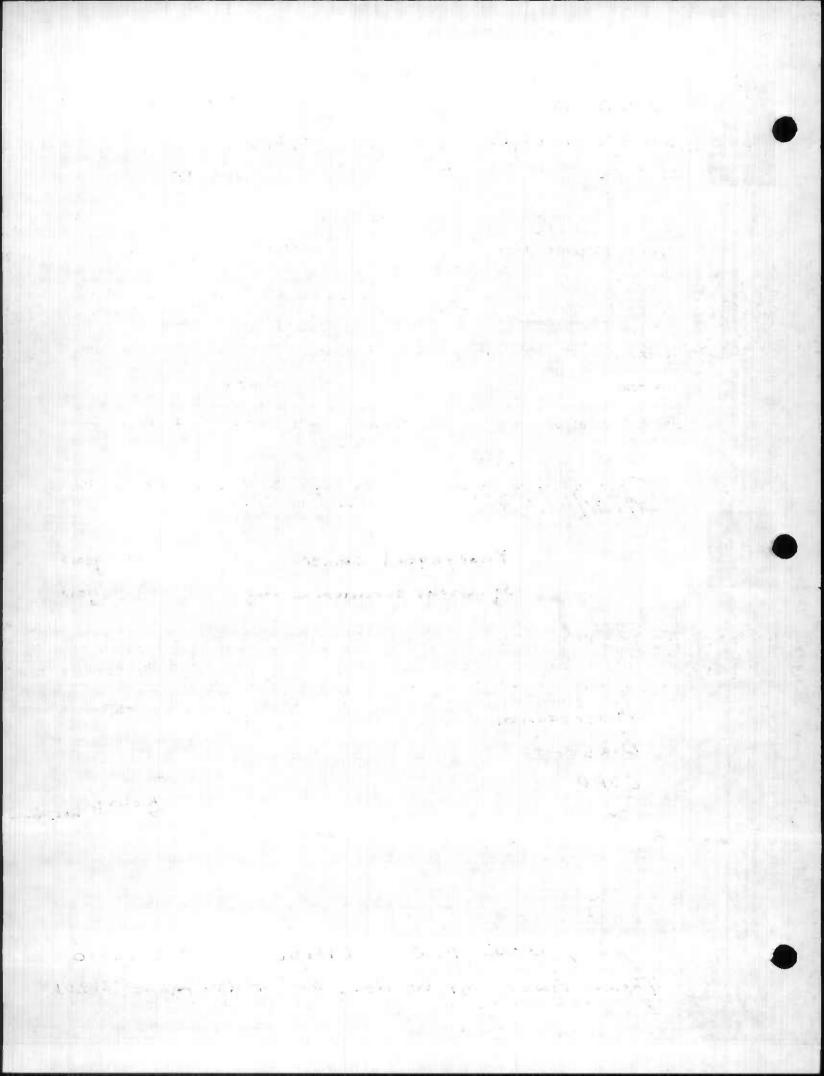
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/ homas

32. Registrar's Signatura

W.

Baltimore 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** : 20 AM 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner owson 0 more 5. Social Security Number TIMORE If Under 24 Hrs. # Under 1 9. Birthplace (State or Foreign S, CARO IN A 7. Age (In yrs. last birthday) **Funeral** 15M 2DF Days Months 217-03-890 Director Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Nerne 23a or 28a-f short 1 Yas 2 No MARYland MORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Land 2121 STREE Funeral flied within 72 hours after deeth 12. Was Decedent Ever in U,S. Armed Forces?/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 21215-0020 1□Yes 20 No Specify Specify: ACK þ parmit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any Injury or other traumatic avant, my Medical Example. 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DETHIER ADORE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be INSO TAYWARE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GWENdol 529 W /ds Inston 7,212/2 Baltlmore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MORIAL 22 Name and Address of Facility 21. Signature of Funeral Service Licenses md, 21229 4-101 Edmond Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical with scrotal rectal Abscess Examiner ongrene The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): colon Box 68760, metastatic envs Concer Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? o 3 Probably 4 Unknown ate hes been signed by page 2 should be detec 1 Yes 2 No 0 2000 Be Completed by SEINSON Se Seconds 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2. No 1 Yes 2 No Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 | Nursing Home 5 | Residence 8 | Other (Specify) | 05 pice Certification: To 1 ☐ Yes 2 ◯ No Division of this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of After 5 Pending investigation Natural death. 1 Yes 2 No or Attendi 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours To the Funeral Completaly filled Hospital 29a. Certifier 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature-and title-of certifies and address of person why completed cause of their (Item 23a) (Type, Print) Charles St. Bulto. md 21284 6201

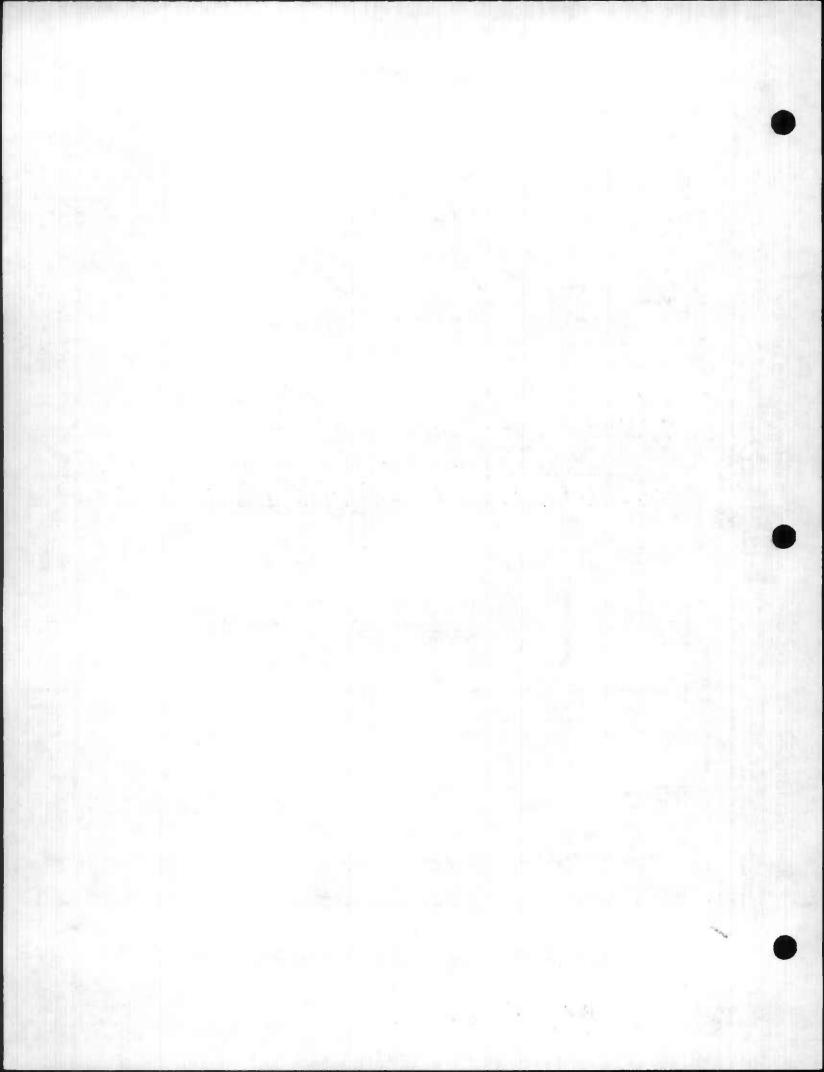
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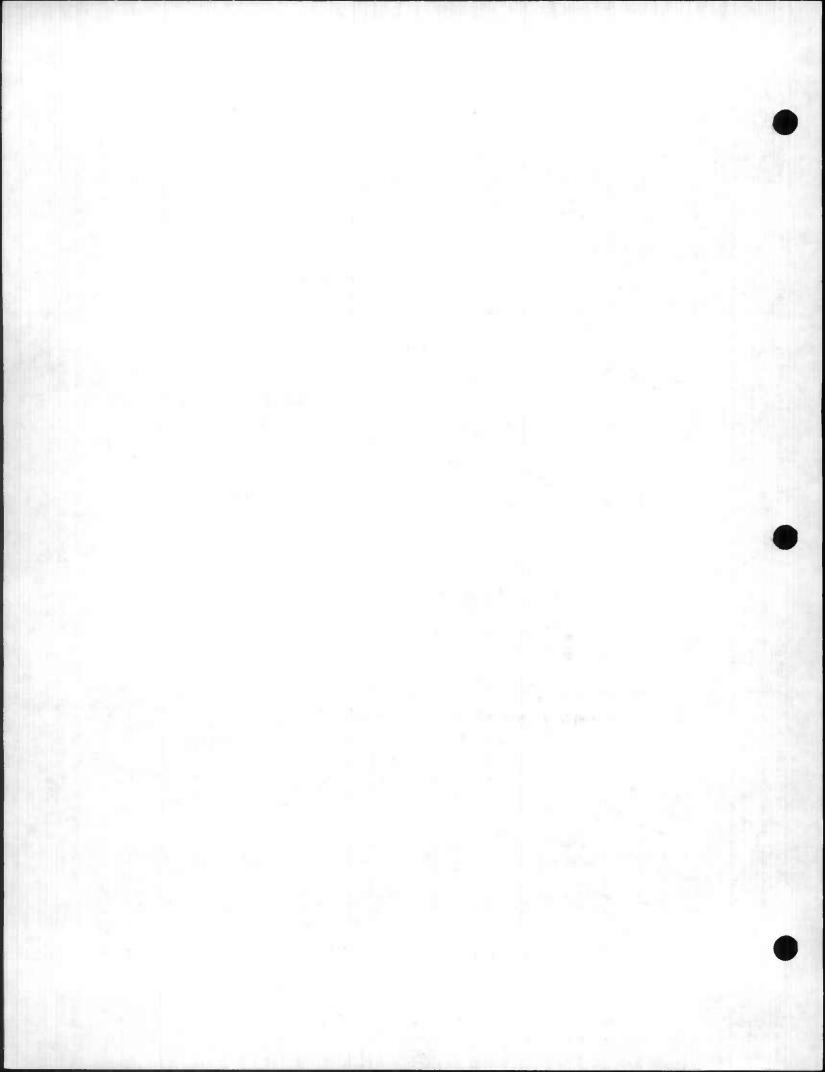
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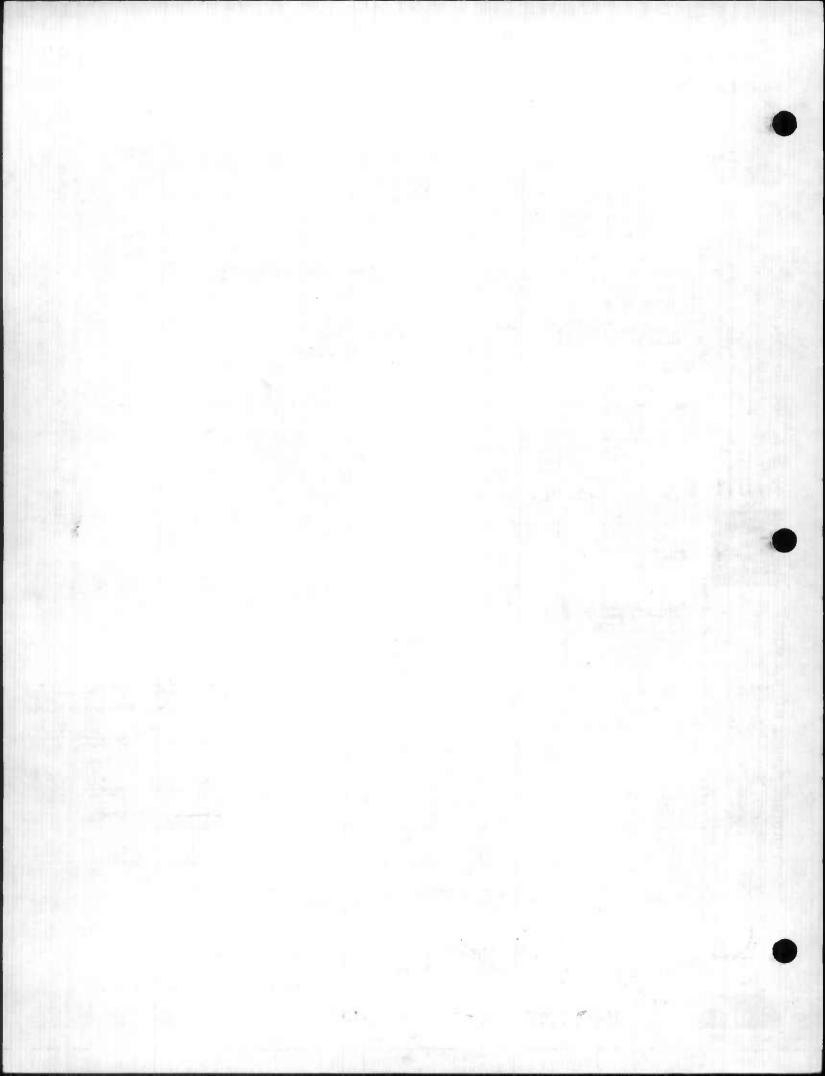
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	Physicia	an	Decedent's Nama						2002			2. Data of Do Month	Day	Yaar	Time of Death	
	/Medic	_	4s Facility Nama (If	SIDNE not institution		and number)		RUBI	.N	4b. City, Town, or L		23, 2000 th 4c. County		30 P.M.	
	Examin	er	MILFORD		1000						BALTIMORI					
	Funeral		5. Social Security Nu		6. Sex	7. A	Aga (fn yrs. last birthday) H Undar 1 Yaar H Undar 24 Hrs Months Days Hours Min					8. Data of Bi (Month, D		112	(Stata or Foreign	
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cuted	an and inal-transit	Examiner	Sequentially list con	ditions.	b. —		Due to (or as a cons	equanca of):	_						
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certificate	attending physicia d for use as the bur	Physician/Medica	rasulting in death) L	ast	d		Dua to (c	or as a consi	squarros ory.							
death	the atter	sicial	Part II. Other algnific	cant condition	ona contributie	ng to death i	out not ras	sulting in tha	undarlying car	usa gi	ivan in Part I.	23b. Did	i tobacco usa co	ntribute to the	cause of death?	
s that the	igned by the attendin be detached for use	by Phy	Cox	ANG	ex)	ART	ER	4 2	ISEX	45	E	10	Yes 2046	3 Probabl	y 4 Unknown	
w requires	pluod:	Completed b			/			(24a. Wa par	s an autopsy formed?	availab	lutopsy findings la prior to ation of causa h?	
The law	certificate has t lirector, page 2 s	omp										10	Yas 2010	1 □ Ya		
	tor, p	0	25. Was casa rafarro	ed to medica	1						26. Placa of Dec					
ysick	0 0	ToB	axaminar?	16	Hospita	t: 1 🗆 Inpat	ient 2] ER/Outpati	ent 3 DOA	A Ot	thor:		sidanca 6 Oth	ar (Specify)		
Attending Physician:	leath. for: After this the funeral c cation: T		27. Mannar of Death 1 ☐ Naturat 2 ☐ Accident	5 Pandir invasti	ng	. Data of Inj (Month, D	ury sy Year)	28b. Tima Injury	of 28		iry at ork?] Yas 2 ☐ No	28d. Dascribe	how injury occur	red		
or Attending			3 Suicide 4 Homicida 6 Coutd not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Inc.) City or Town, State)										per or Rural Ro	uta Number,		
Hospita	within 24 hours after of to the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)	1 Certifyir 2 Wedical	Examiner: O	To the best n the basis of nd manner s	of axamina	owledga, das ation and/or	ath occurred at invastigation, i	t tha ti	ima, data and ptaca opinion, daath occur	, and dua to the red at tha time	a causa(s) and ma , data and place,	annar as stated and dua to tha	d. cause(s)	
To th	Toth	Me	29b. Signature and	tis of certifie	1				29c.	Lican	sa number		29d. Data signe	d (Month, Day,	Year)	
			M	aus)	Make	use	1		1	0 9	51896		3/2	24/00)	
9	h		30. Name and addra	ss of person	who complate	ed causa of	daath (Ite	m 23a) (Typ						1		
_	0			MALIN					r ROAD	#6	10 PIK	ESVILLE	, MD 212	808		
	Stat	e	31. Data fited (Mont/	h, Day, Year)		32. Regist	rar's Signi	atura	, -							

Registrar DHMH 16 Rav 6/95

MAR 2 7 2000



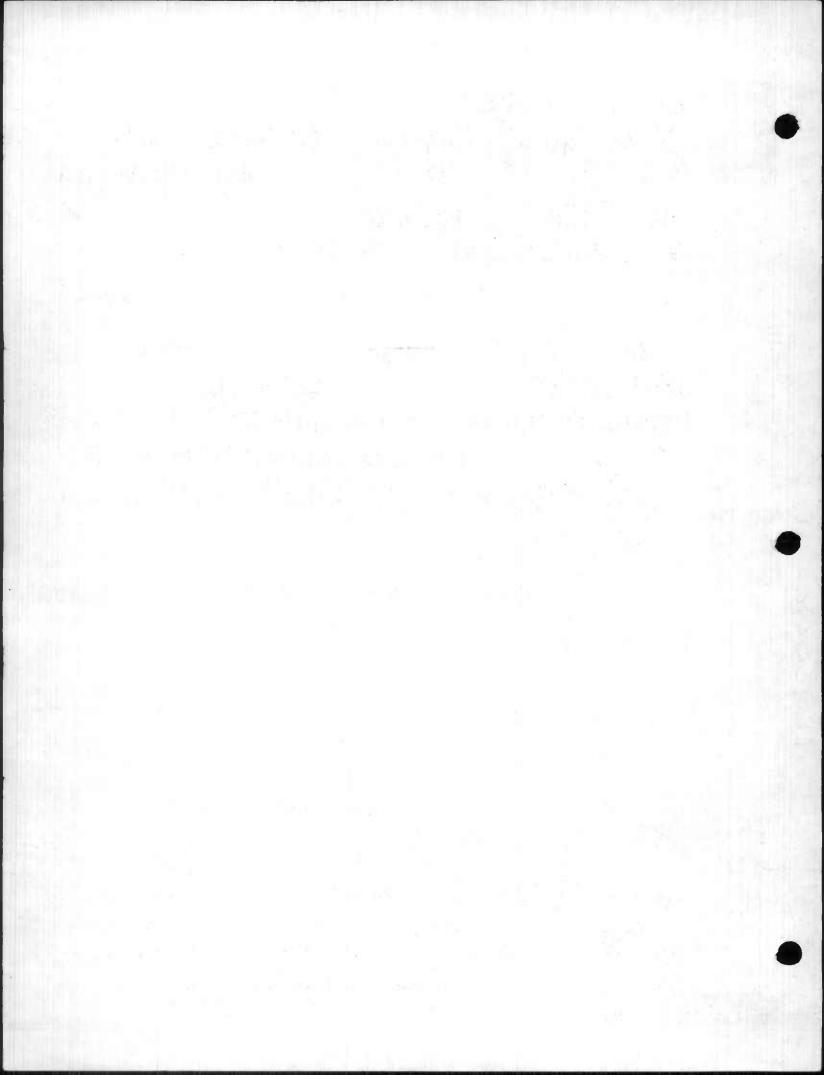
sician	1. Decedent's Name (First, Middle Cathy A		3/27/00		tificate of		2. Dete of De Month	Day	3. Time of Death			
edical	4a Facility Name (If not institution		mhar)			4b. City, Town, or Lo	FEBRU					
miner	511 SOUTH VIN					BALTIMOR:	NT / A					
ral tor	5. Social Security Number 212-02-3631	6. Sex 1 M 2 XF	7. Age (In yrs. las 29	si birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir	th (Year) 1970	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent 10s. State 10b. County		10c City	Town or Lo	cation				10d. Inside City Limits			
ğ		timore			Balti	lmore			1 ☐ Yes 2 ☐ No			
al Director	10e. Street and Number 2034 Armco	Wav			10f. Zip Code	21222	100	10g. Citizen of V	What Country? USA			
by Funeral	11. Maritat Status 1 N Never Married 2 Marr 3 Widowed 4 Divorced	12. Wes Deci	2No			Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Rac Bled Specify	e-American Indian, ck, White, etc. c: White			
Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)		I-dor 5+)	16a. Deced (Give life. D	lent's Usual Occu kind of work done DO NOT use retire	pation a during most of work ed)	ing	16b. Kind of Bi	usiness/Industry			
Com	7		40104)		Never Wo	_		N/A				
To Be	17. Father's Name (First, Middle,					18. Mother's Nam	e (First, Middle	, Maiden Suman	70)			
	Harry Joseph Sears 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or It							iller	State Zin Code)			
	Tammy D. Sears/				4 Armco			MD 21222				
	20a. Method of Disposition		20b. Ple		sition (Name of natory or other pla		Date		City or Town, State			
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			o Crem	natory,	Inc. 2,	/26/00	Ва	altimore, MD			
	21. Signature of Funeral Service Licensee () () () () () () () () () (
	Dawn F 23a. Part1. Enter the disease, or	McDonald	- Nortal	K 199	Freder	ick Road	Baltime	ore, MD	21228			
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. LIVER	CIRRHOSIS Due to (or a	as a conseq	uence of):				Onset and Death			
_	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C										
by Physician/Medica	that initiated events resulting in death) Last Due to (or as e consequence of): d											
alc la	Part It. Other significant condition	ens contributing to de	eath but not result	ing in the un	nderlying cause g	iven in Part I,	23b. Dld	tobacco use co	ntribute to the cause of death?			
by Phy			intributing to death but not resulting in the underlying cause				1 🗆	Yes 2 No	3 Probably 4 Unknown			
Completed								an autopsy ormed?	24b. Were autopsy tindings evailable prior to completion of cause of death?			
Con							150	Yes 2□No	1 Yes 2□ No			
Be	25. Was case referred to medical examiner?	Hospital:			10	26. Place of Deat						
5.	1 ☑ Yes 2 ☐ No 27. Manner of Death	101		R/Outpatient	t 3□ DOA			dense 6 10th	er (Specify)SCENE			
ification	1 Netural 5 Pendin 2 Accident investig 3 Suicide 6 Could	not be 28e. Placa	of tnjury - At hom	Yes 2 No	28f. Location (Street and Numb	per or Rurel Route Number.					
Certification:	4 Homicoe	g Physician: To the	City or To		enner as stated							
-		Examiner: On the ba	asis of examinationer stated.	n and/or inv	estigetion, in my	opinion, death occur	red at the time,	date and placa,	and due to the cause(s)			
edical												
edical	29b. Signature and title of certifie) M	14						d (Month, Day, Year) Y 20, 2000			



DHMH 16 Rev 6/95

State Registrar

MAR 2 7 2000



State of Maryland / Department of Health and Mental Hygiene

Ranch Part	ysician	1. Decedent's Name (First, Middle, La Julia Anna Silbe					2. Dete of De Month	Dey	Year 3. Time o				
St. Agres Hospital St. Ag	Medical _					Ab Ch. Town or							
215-16-6424 10	aminer							4c. County	or Death				
The Steel and Number 100. County 100. City / Town of Locality 101. Top Code 110. Steel and Number 101. Steel and Number 102. Steel and Number 102. Steel and Number 102. Steel and Number 103. Steel and Number 103. Steel and Number 104. Steel Andread 104. Stee	erai			77	Months Days		(Month, De	th by, Year) , 1922	9. Birthpleca (Stete Country) Maryland				
The Street and Number 101. Zee Code 102. To Code 102. The	4	10a. Stete 10b. County						10d.					
The content of the	recto			<u> </u>	10f. Zip Code		10a. Citizen of V						
Security	0 0		t.										
George Greiser See Informer's Nemorificationship (Type, Print) George W. Silberzahn, spouce Job Meiorg Address (Street end Number of Ryall Route Number, Cap or Towy, State Joseph Job Code) Job Meiorg Address (Street end Number of Ryall Route Number, Cap or Towy, State Joseph Job Code) Job Meiorg Address (Street end Number of Ryall Route Number, Cap or Towy, State Job James Stown Ct. Baltimore, MI Job James Stown Ct. Baltimore, MI Job Piccs of Disposition (Neme of Comercial Storage) Job Piccs of Disposition (Neme of Comer	P A	1 Never Merried 2 Merried	Armed Forces? 1 Yes 2 No If Yes, Give	or in U,S.									
George Greiser See Informer's Nemorificationship (Type, Print) George W. Silberzahn, spouce Job Meiorg Address (Street end Number of Ryall Route Number, Cap or Towy, State Joseph Job Code) Job Meiorg Address (Street end Number of Ryall Route Number, Cap or Towy, State Joseph Job Code) Job Meiorg Address (Street end Number of Ryall Route Number, Cap or Towy, State Job James Stown Ct. Baltimore, MI Job James Stown Ct. Baltimore, MI Job Piccs of Disposition (Neme of Comercial Storage) Job Piccs of Disposition (Neme of Comer	eted	15. Decedent's E	ducation ade completed)	16a. D	ecedent's Usuel Occu	pation during most of wor	rking	16b. Kind of Bu	usiness/Industry				
15. Member's Name (prist, Mode, Last) 15. Member's Name (prist, Mode, Mode) 15. Member's Name (prist, Mode, Mode) 15. Member's Name (prist, Mode	Idu	Elementery/Secondery (0-12)					Our he	am o					
George Greiser 19e. Informer's Nemer's Reiner State (Character) (Type, Print) 20e. Method of Disposition 19e. Silbertzaln, spouce 21. Signature of Funeral Services (Jonnesee 22. Name and Address of Fecility 22. Name and Address of Fecility 23. Name and Address of Fecility 24. Name and Address of Fecility 25. Silbertzaln, spouce 27. Name and Address of Fecility 28. Name and Address of Fecility 29. Name and Address of Fecility 21. Signature of Funeral Services (Jonnesee 21. Signature of Funeral Services (Jonnesee 22. Name and Address of Fecility 25. Method of Disposition 26. Sequentials (International Collection City of Town, Stet Services, or heart failure. List only one cause on each line. 27. Name and Address of Fecility 28. Supplemental Services (Jonnesee) 28. Sequentials (International Collection City of Town, Stet Services, or heart failure. List only one cause on each line. 28. Advantage of Character (Jonnesee) 29. Sequentials (International Collection City of Town, Stet Services, or heart failure. List only one cause on each line. 29. Due to (or as a consequence of): 29. Due to (or as a consequence of): 29. Care Collection City of Town, Stet Services, or heart failure. List only one cause on each line. 29. Care Collection City of Town, Stet Services, or heart failure. List only one cause on each line. 29. Were cause referred to medical examination and or investigation (Medical Examination Collection) 29. Care Collection City of Town, Stete Services, and Services an			0	по	memaker	18. Mother's Nar							
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Security		19e. Informent's Neme/Reletionship (Type, Print) Lahn, spouse	leiling Address (Stree Jamestown	tend Number or Ru Ct. Ba.	ral Route Numb	er, City or Town, MD 2	State Zip Code)					
22. Name and Agrices of Fecility Ambrose Fruneral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227. Approximately a sulphur Spring Rd. Arbutus, MD. 21227. 23a Perti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, interest interest in the disease or conditions. In the disease or conditions or sulphur sulphu	ry or other	1 Burial 2 Cremetion 3 C	JHJemovai Irom State			Dete 20c. Location - City or Town, Stete							
23a Perfl. Enter the disease, or boundings accessed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, indicated limited cause (Fine) as a consequence of the condition of accessed to condition or accutating in death) 25a Perfl. Enter the disease or conditions or accessed to each line. 25a Perfl. Enter the disease or conditions or accessed to each line. 25a Perfl. Enter the disease or conditions or accessed to each line. 25a Perfl. Enter the disease or conditions or each line. 25a Perfl. Enter the disease or conditions or each line. 25a Perfl. Enter the disease or conditions or each line. 25a Perfl. Enter the disease or conditions or each line. 25a Perfl. Enter the disease or conditions or each line. 25a Perfl. Enter the disease or conditions or each line. 25a Perfl. Enter the disease or conditions or each line. 25a Perfl. Enter the disease or conditions or each line. 25a Perfl. Enter the disease or conditions or each line. 25a Perfl. Enter the disease or condition or each line. 25a Perfl. Enter the disease or condition or each line. 25a Perfl. Enter the disease or condition or each line. 25a Perfl. Enter the disease or each line. 25a Perfl. Location (Check only only only only only only only only	any Inju	21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227											
design of the part	ian	Immediate Cause (Finel	1				,		Approxime Interval Be Onset and				
Pert II. Other eignificant conditions contribute to the cat Pert III. Other eignificant conditions contribute to the cat Pert III. Other eignificant co	edical	that initieted events	b. CORONAI Du	e to (or as e con	TERY DI	SEASE			10 ye				
25. Wes case referred to medical examiner? 1	sicis	Pert II. Other eignificant conditions of	contributing to death but n	ot resulting in the	ne underlying cause g	iven in Pert I.	23b. Did	tobacco use co	ntribute to the cause				
25. Wes case referred to medical examiner? 1	Phy	BREAST CARCI	Noma /r	NASTE	CTamy		10	Yee 2010	3 Probably 4				
25. Wes case referred to medical examiner? 1		•			24e. Wes	s en eutopsy ormed?	24b. Were autopsy eveilable prior completion of						
25. Wes case referred to medical examiner? 1	should be						10	Vac 2000	,				
27. Menper of Death 1 Neturel 27. Menper of Death 1 Note urel 28a. Dete of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury et 28c. Injury et 28c. Injury et 28d. Describe how injury occurred 28d. Desc	age 2 should be						, , ,	100 24.10	1 .0.00 Ea				
Neture 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 5	tor, page 2 should be					26. Plece of De	ath (Check only	one)					
29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signeture and title of certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Ye)	director	examiner?	Hospitel:	2 ER/Outp	atient 300A O	han			ner (Specify)				
29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check anly one) 29b. Signeture and title of certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Ye)	To Be	examiner? 1 Yes 2 No 27. Menger of Death 1 Neturel 5 Pending	28a. Dete of Injury (Month, Dey Yo	28b. Tin	ne of 28c. Injury	ther: 4 Nursing harry et ork?	lome 5 Res	idence 6 Oth					
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1) 22648 MARCH 24, 2006	the funaral director cation: To Be	examiner? 1 Yes 2 No 27. Menger of Death 1 Neturel 5 Pending investigetion 3 Suicide 6 Could not be determined 29a. Certifier (Check only) 2 Medical Examination	28a. Dete of Injury (Month, Dey Young) 28a. Pleca of Injury building, etc. (s) 28a. Pleca of Injury building, etc. (s) The publican: To the best of mainer: On the basis of ex	- At home, ferm Specify) ny knowledge, camination and/	ne of learning and	ther: 4 Nursing F ury et ork? Yes 2 No	28d. Describe 28f. Location City or To	idence 6 Oth how injury occur (Street end Numl wm, Stete)	ber or Rural Route Nut				
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)	the funaral director cation: To Be	examiner? 1 Yes 2 No 27. Menper of Death 1 Neture 5 Pending investigetion 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physics Could not be determined	28a. Dete of Injury (Month, Dey Young) 28a. Pleca of Injury building, etc. (s) 28a. Pleca of Injury building, etc. (s) The publican: To the best of mainer: On the basis of ex	- At home, ferm Specify) ny knowledge, camination and/	ne of	ther: 4 Nursing Funy et ork? Yes 2 No ime, date end pleck opinion, deeth occurse number	28d. Describe 28f. Location City or To	idence 6 Oth how injury occur (Street and Number) occurs (Street and Number	ber or Rural Route Nur enner as stated. and due to the ceuse(ed (Month, Day, Year)				
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) DENOME J. SNYDER M.D. 900 SOUTH CATON AUENUE BALTIMORE, MARYLAND State Registrar MAR 2 7 2000 Separate MAR 2 7 2000 S	completely filled in by the funeral director Medical Certification: To Be	examiner? 1 Yes 2 No 27. Menger of Death 1 Neturel 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signeture end title of certifier	28a. Dete of Injury (Month, Dey Young) 28a. Pleca of Injury building, etc. (state of the best of mainer: On the basis of exemple of the basis of the basis of the basis of exemple of the basis of exemple of the basis of the basis of the basis of exemple of the basis	ear) 28b. Tin Inju	ne of a per of the form of the	ther: 4 Nursing Funy et ork? Yes 2 No ime, date end plectopinion, deeth occurse number	28d. Describe 28f. Location City or 7d a, end due to the time	idence 6 Oth how injury occur (Street and Numbers, State) cause(s) and min, date and placa, 29d. Date signe	enner as stated. and due to the ceuse(and (Month, Day, Year)				

ORIGINAL

4

SILBER ZAHN, JULIA

o the Hospital

State Registrar

DHMH 16 Rev 6/95

Chuteno Dennis J. 31. Date filed (Month, Day, Year) MAR 2 7 2000

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

bufo w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

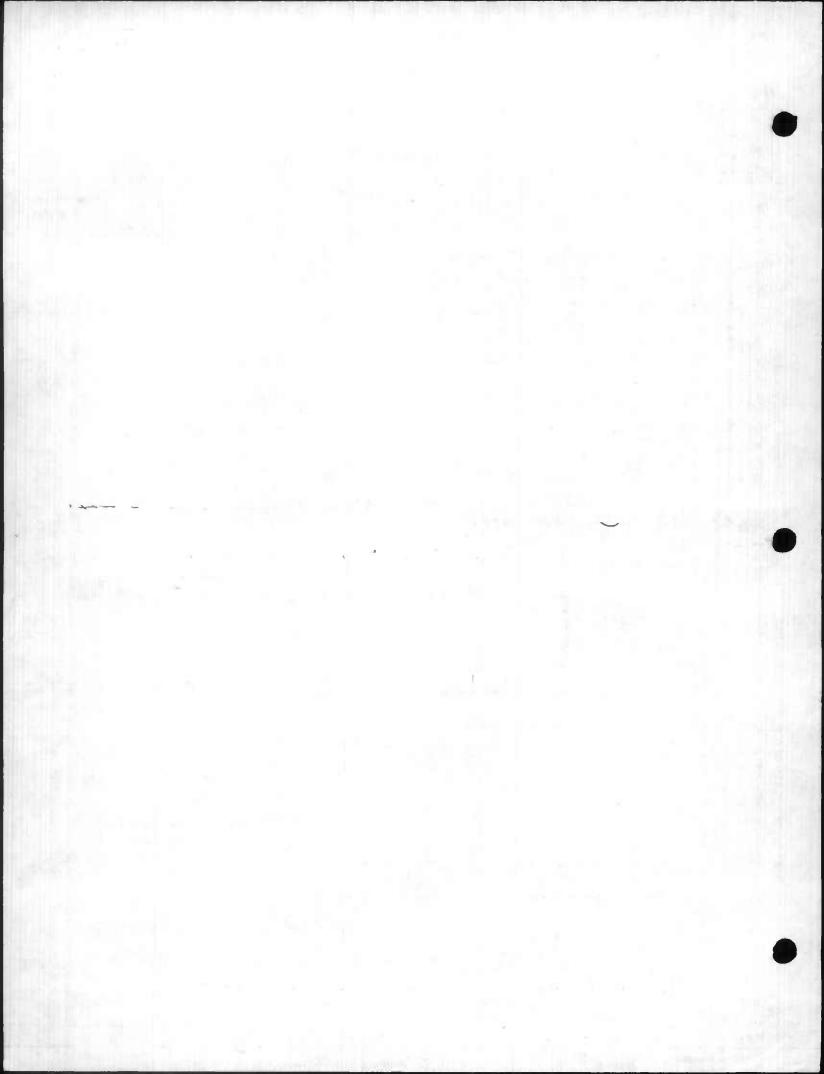
111 Penn Street, Baltimore, Maryland 21201

29c. License number

OCME

29d. Date signed (Month, Day, Year)

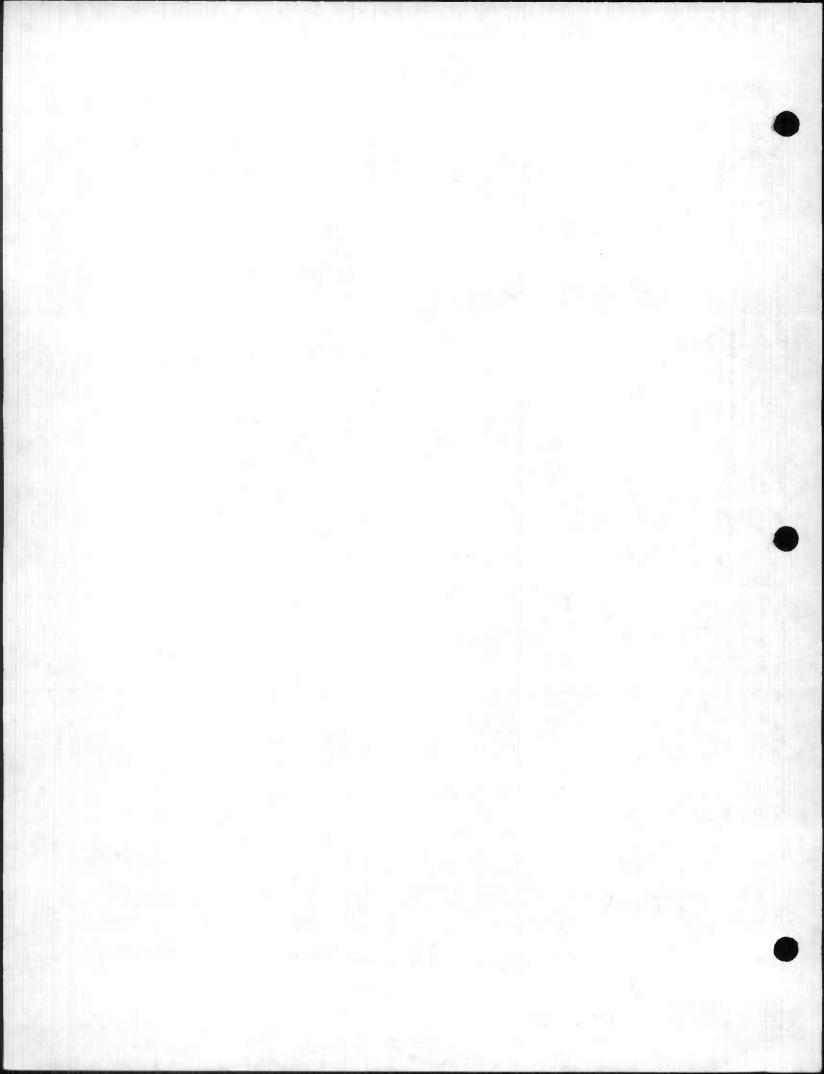
MARCH 22,2000.



State of Maryland /	Department	of Health	and	Mental	Hygiene
	O-Williams	-4 D46			

							Ce	Hunca	ie oi	Death			Reg. No.		000
Inland	1. 0	Decedent's Nam	e (First, Midd	lle, Last)								2. Dete of De Month		Year	3. Time of E
ician dical		J			W	ALTER		STE	INHAF	RDT		MARCH	24, 200	0	1:25 A
iner	4a	Facility Neme (/	f not institutio	n, give s	street and nu	ımber)				4b. City, Tov	vn, or Lo	ocation of Death 4c. County of Death			1
		6607 AM	LEIGH	ROAL)					BALTI	1				
	5. 5	Social Security N 215-18-	6825	6. Sex	(}M 2□ F	7. Age (In yrs			If Under 1 Year If Under 24 Hrs Months Days Hours Min			8. Dele of Bir (Month, De	y, Year)	9. Birth	place (Stete or untry)
				1,3%	2141 2111	7	7 Yrs.					JAN. 4	1923		GERM
thems 23s or 28e / show siner must be notified at Furneral Director		uai Residence of a. State	10b. County	/		10c. C	ity, Town or L	ocation							10d. Inside City
		MD	D3.F.M3	rMOD	_										1 Yes
		MD BALTIMORE BALTIMORE 10e. Streel and Number 10f. Zip							in Code			10a Citizen of	What Cor	intry?	
								102	, , , , ,	21209	10g. Citizen of What			,	
		11. Marital Status 12. Was Decedent E					J.S. 13.	Wes Dece	edent of H			ecity Yes or No			ican Indian,
		1 Never Merri	ied 2K Mer		Armed F	orces?					Puerto	ecity Yes or No Rican, etc.)	Bla	ck, White	, etc.
Completed by F	3 Widowed 4 Divorced It Yes, Give				ive WW	TI	1 Tes	2 No	Specify:			Specia	fy:	WHITE	
	15. Decedent's Education (Specify only highest grade completed)					16a. Dece	edent's Usi	ual Occup	pation			16b. Kind of B	Business/l	ndustry	
	(Specify only highest grede completed) Elementary/Secondery (0-12) College ((Give	DO NOT	ork done use retire	during most d)	of work	ing				
	Elementary/Secondery (0-12) College (1-4or 5-					(1-401 54)	CERT	IFIED	PUBI	LIC AC	COU	NTANT	ACCOUN	TING	
	17. Father's Name (First, Middle, Last)					-				18. Mothe	r's Nam	e (First, Middle	, Meiden Sume	me)	
ry or other traumetic even	ZIGMUND						STEINE	HARDT		BERT	HA		Ī	METZO	GER
	19a. tnformant's Name/Relationship (Type, Print)						19b. Mail	ling Addres	ss (Street	end Numbe	r or Rur	al Route Numb	er, City or Town	, State, Z	ip Code)
		LEAH STEINHARDT / WIFE					6607	7 AML	EIGH	ROAD	- B	ALTIMOR	E, MD 2	1209	
	20a. Method of Disposition						Place of Disp cemetery, cre	position (Ne	other ple	ce)		Date	20c. Location	- City or T	Town, State
	20a. Method of Disposition 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)				emovel from		EVRA A				13	/24/00	RANDA	LLST	OWN, MD
	21.	. Signeture of Fu	nerat Service	License	90					ss of Facility			SON & B		
any le						8900 REISTERSTOW							DOM OF D	IVAJ B	
	23	3a. Part1. Enter the shock, or hee	the disease, o	or complice t only on	cations that ne ceuse on	ceused the des					WN 1	ROAD -	PIKESVI		
	Im	3a. Part1. Enter to shock, or hee amediate Cause (sease or condition sulting in death)	(Final	or complication only on	cations that he ceuse on	ZONE		anter the mo	ode of dyin		WN 1	ROAD -	PIKESVI		MD 2120 Approximate
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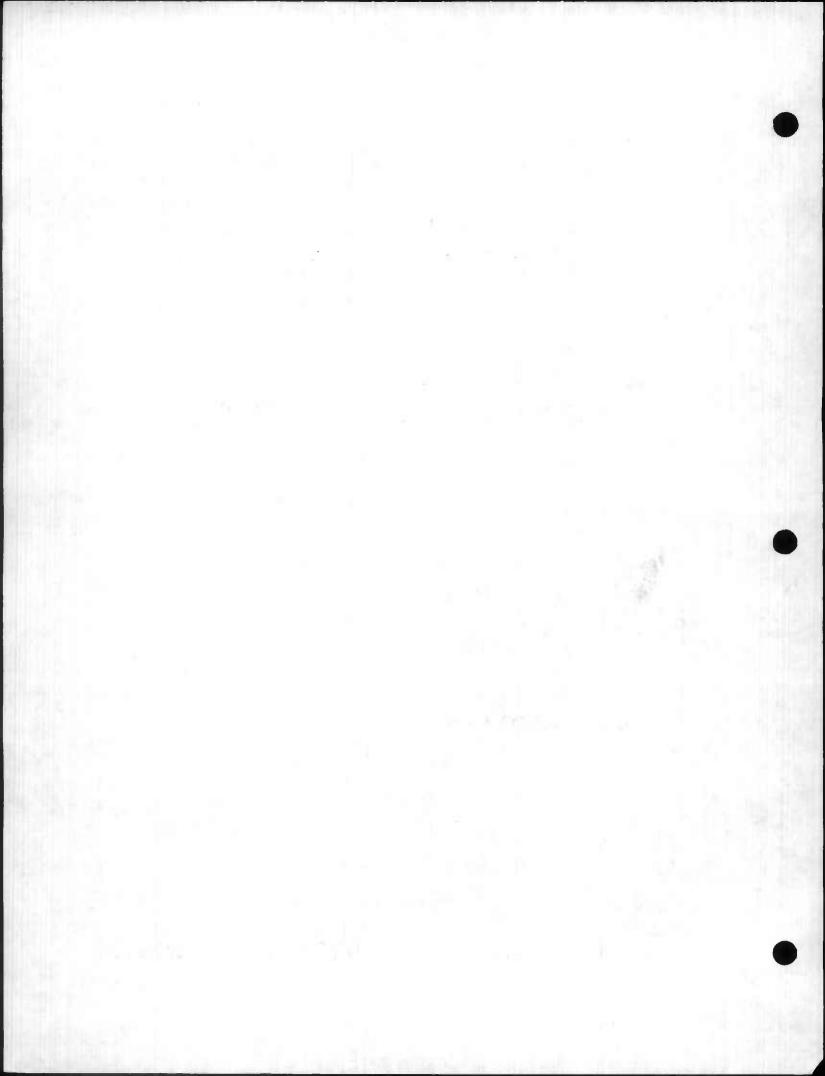
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middia, Last) 2. Date of Death 3. Time of Death 2 5 2000 **Physician** 8 pm. Melvin Clifton Travers M . rc /Medicai 4a. Facility Name (If not Institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner 5. I ton. e As he - 1 N/A If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 6. Sex 1 → M 2 □ F 8. Dete of Birth (Month, Day, Year) Mar 27, 1915 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign MD Country) Funeral Months 84 Yrs. 214-07-9284 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ United States 21202-238 1804 Ashland Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: ||Iems 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours after onent of Health end Mental Hygiene. Int: If Itam 27 is marked other then "netural", or Nei 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specifyick by 3 ☐ Widowed 4 🎽 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Steel Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Travers Griffin Mary Department of Health end Important: If Itam 27 is m any injury or other traum once. 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Evelyn Keene- Niece 631 Stirling Street, Baltimore, MD 21202 20a. Method of Disposition 20b. Placa of Disposition (Name of cematery, crematory or other place) Date 20c. Location - City or Town, State Apr 1 1 Burial 2 □ Cramation 3 □ Removal from State Taylor Island,, MD 2000 4 ☐ Donation 5 ☐ Other (Specify) Lanes United Methodist 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medicai Immediate Ceuse (Final diseasa or condition rasulting in death) **Examiner** -dissible diserse Examine sician end burial-transit Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician the burial Physician/Medicai Due to (or as a consequence of): signed by the eld d be deteched for Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yas 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was cese referred to medicel exeminer? 26. Plece of Deeth (Check only one) Be exeminer? 1 X Yes 2 □ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation efter death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 29a. Certifier Medicai 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29b. Signatura and titia of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 3015+. P.- 1 Plue #815 B. 30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

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32. Registrar's Signature

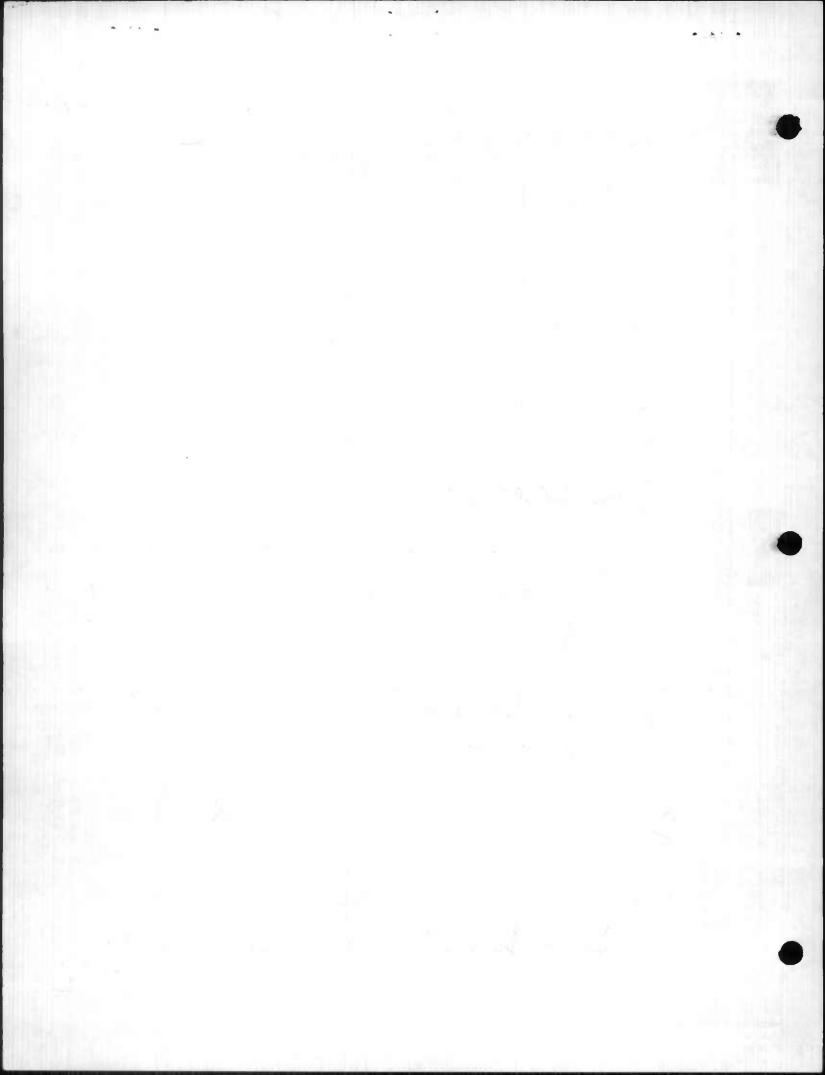
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DHMH 16 Rav 6/95

State

Registrar

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amende ditem#26 perPHYg781 3/27/2000 EW 1. Decedant's Nama (First, Middle, Last) 2. Data of Death **Physician** EK HOMAS 2000 /Medical

3:45 Am Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) tospital on Secours 7. Age (In yrs. last birthdey) 38 Yrs. If Under 1 Year 5. Social Security Number Birthplace (State or Foreign
 Country) **Funeral** Months Deys 1 M 2□ F 216-74-4446 Director August 22 1961 MARyland Usual Rasidenca of Dacedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, it a Medical Examiner must be notified at 1 Yas 2 No Director MARyland none 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda HRling USA 1005 21217 by Funeral death 12. Wes Dacadant Evar in U,S. Armed Forces? 1 ☐ Yas 22 No If Yas, Giva Yaar or Detes: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Stetus Peges 1 and 2 should be filed within 72 hours after intent of Health and Mertal Hygiene.

The filam 27 is marked other than "natural, or itea into yor other than that is a Medical Examinating or other traumatic event, its Medical Examinating. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No 3 ☐ Widowed 4 ☐ Divorced TROAMERICAN Completed 15. Dacadant's Education 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry (Specify only highest grede completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 1214 Dishwosher topkins PlazA Deli 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Surname) Be Her bert Thomas Fenwick Lillie Mae 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) ARlington BAthmore, MARULAND 21215 Wilburn-(Sister) Ave, 1005 N. 3 Pata Mathod of Disposition
1 ☐ Burial 2 (Cramation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Neme of cametery, cremetory or other placa) 20c. Location - City of Town, Stata Lonsville, MARyland Department Important: It any Injury o EtRO 4 Donation 5 ☐ Other (Specify) 2000 22. Nama and Addrass of Facility NAncy 21. Signature of Funeral Sarvice Licensee WALLACE 105 W. France, Wellace 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximeta interval Batween Onsat and Death **Physician** /Medical Immadiata Ceuse (Final PNEUMONIS disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed buriel-trensit Sequantially list conditions, if any, laading to Immediata cause. Entar Undarlying Ceuse (Disaasa or Injury that Initiated events rasulting In daath) Last Dua to (or as a consequence of): Disease physician s the buriel P.O. Box 68760. Tage Physician/Medicai Dua to (or as e consequenca of): 98 IMMUNODE FICIENCY SYN DROME Quired nse use 0 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuss given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No signed b Records, þ 24b. Wera autopsy findings availabla prior to completion of causa of daath? is certificate has been si director, pege 2 should Completed 24e. Wes an autopsy 22100 this certificate 1 Yas Division of Vital Hospital or Attending Physician: Be 25. Was casa referred to medical 26. Pleca of Death (Check only one) axaminar? Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA No No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas funeral Date of Injury (Month, Dey Year) 27. Manpar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After Naturel 5 Panding 1 Yas 2 🗆 No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fo 2 Accident investigation 3 Suicida 6 Could not be datarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier Cartifying Phyalclan: To the best of my knowledge, deeth occurred et the time, dete and piace, end due to the cause(s) and menner as stated.

2 Medical Examinar: On the bests of examination and/or invastigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and manner stated. Medicai 29c. Licansa number

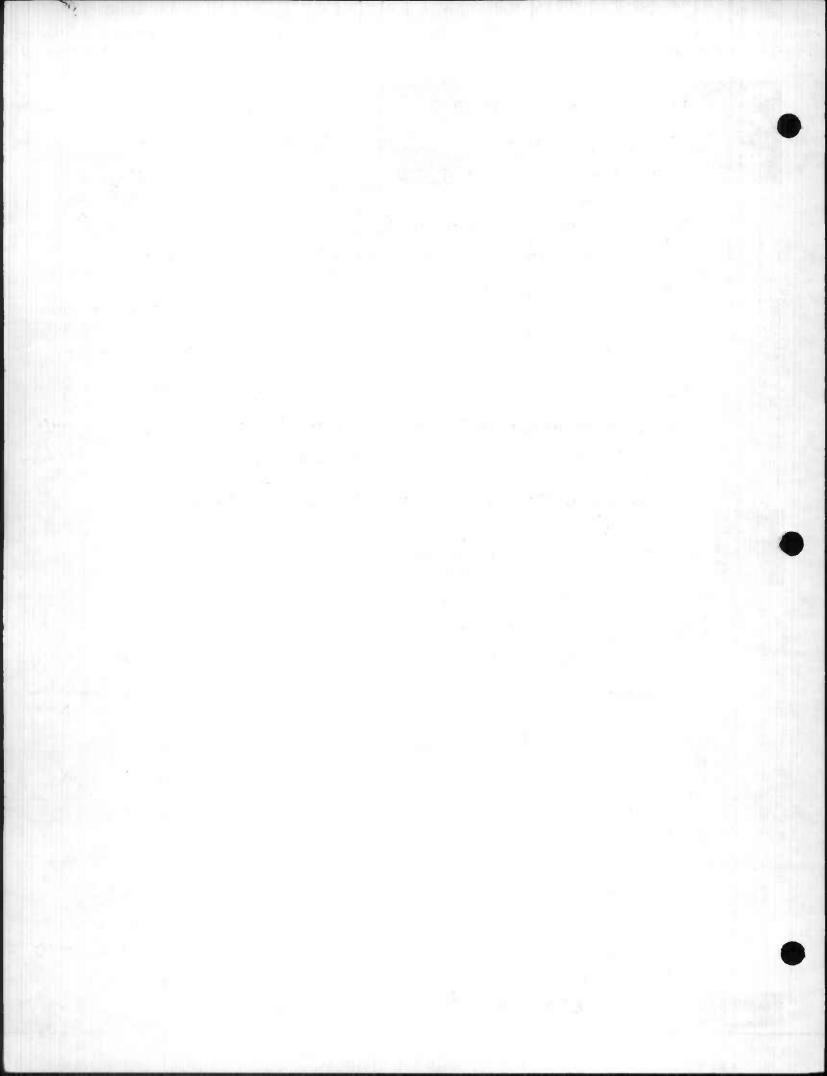
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29d. Data signed (Month, Day, Year)

State Registrar 29b. Signatura and titla of certifier

31. Data filed (Month, Dey,

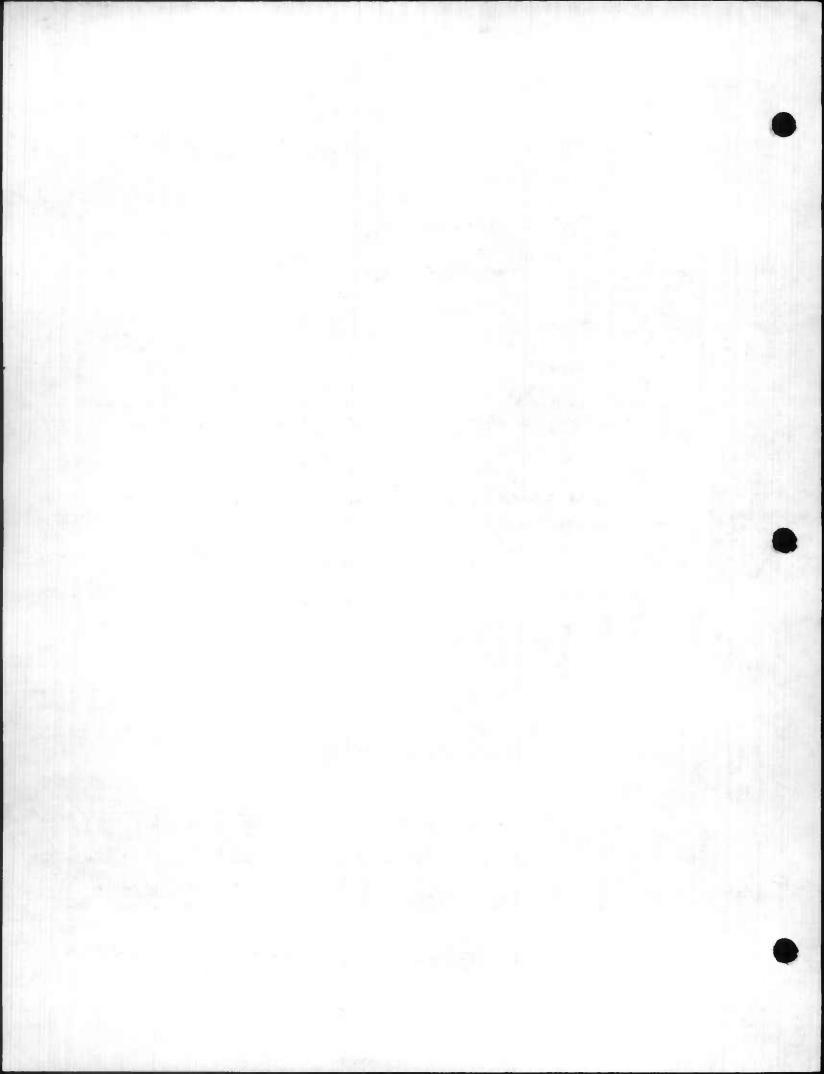
30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygien 0 09895

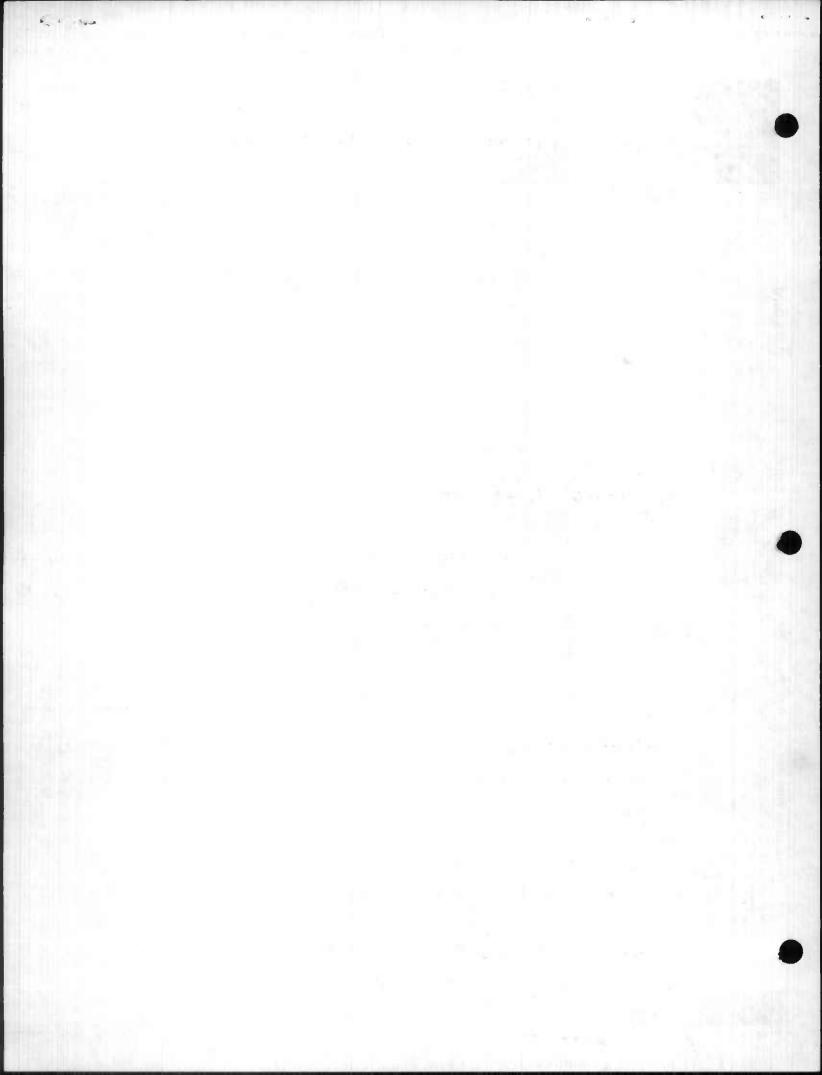
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Dhualai		1. Decedent's Neme (First, Middle, Li						2. Data of Dea Month	nth Dey	Year	3. Time of Death	
Physici /Medic		John Gerald	wright					March 2	24, 2000	1941	7:00 AM	
Examin		4e Facility Nema (If not institution, gir						r Location of Death				
		3905 Darleigh R	•				Baltimo		Baltimore			
Funeral Director			Sax 7. Ag	96	irthday) If Under 1 Months Yrs.	Year Days	If Under 24 Hr Hours Mir		, 1903	, Coun	lace (Stete or Foreign trx) JLand	
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th wit	aiD	3905 Darleigh R	oad, Apt.H			21	236		u.s	.A.		
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modesi Eseminer must be notified at	by Funeral Director	11. Marital Stetus 1 Never Merried 2 Married 3 X Widowed 4 Divorced	12. Was Dacedent Armed Forces? 1 Yes 2 X ff Yes, Give Yeer or Detes:	Evar In U,S. No	J.S. 13. Was Decedent If Yas, specify 0			Specify Yes or No- into Rican, atc.)	14. Race Blac Specify	k, White,	an Indien, etc. ute	
72 ho	ted	15. Decedent's E (Specify only highest gr	ducation	166	a. Decedent's Usuel (Give kind of work life. DO NOT use	Occupati	ion	ndkina	16b. Kind of Bu	siness/Inc	dustry	
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e filed will Hygien other th	S	7th Grade			Mechani			45 . 14:4.4	Administ		tion	
d be fi	Be	17. Father's Nome (First, Middle, Last Martin Wright	,			1		eme (First, Middle, Ellen McG		8)		
d Me	2	19e. Informent's Neme/Reletionship	Time Print)	10	b. Mailing Address (Street en				State 7in	Code	
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Depart Permit		Bun a.	Willo		Schimun	ek F	uneral	Home, In	ic.	1021		
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/Medical Examiner	iner	Immediate Ceuse (Finel disease or condition resulting In death)	a. Hr.	Due to (or as a	osc /s consequence of):	va.	Tie	Card	io Va	350	16-11e	
68760, ifficate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarrying Ceuse (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):										
BOX 687 atth certificata attending phys for use as the												
death cer death cer e attendir ed for use	sicie	Pert II. Other significant conditions	contributing to death b	ut not resulting	in the underlying cau	use given	in Pert I.	23b. Did t	obacco usa cor	tributa to	the cause of death?	
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UNVISION Of VITAI MECOIDS, P.O. BOX I or Attending Physician: The law requires that the death certifier death. Office to a straight of the sentificate has been signed by the attending of the funeral director, page 2 should be detached for use	Completed							24a. Was perfor	an autopsy med?	av co	are autopsy findings allable prior to mpletion of cause deeth?	
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To the Hospital or Attending Physician: The is within 24 hours after Gasth. To the Funeral Director: After this cartificate ha completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 1 Certiffing Pr 2 Medical Example 1	yaician: To the best niner: On the basis of end menner st	examination e	e, deeth occurred at nd/or investigetion, is	the time n my opir	, dete end pled nion, deeth occ	ce, end due to the courred at the time, o	ceuse(s) and ma date end piece,	nnar as s and due to	tated. o the cause(s)	
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V		30. Name and address of person who	completed ceuse of d	eeth (Item 23a)	(Type, Print) /-/	14	ונמנ	THILI	Rd	21	210	
Sta Registra		31. Data filed (Month, Dey, Year) MAD 9 7 2000	32. Registr	ar's Signeture	Spark	1	1					

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State of Maryland / Department of Health and Mental Hygiene

					Certi	ficate of	Death		Reg. No.) ()	09090		
Dhood		1. Decedent's Name (First, Middle, L	ast)					2. Date of Do	eeth	Van	3. Time of Death		
Physic /Med		Cleveland Wilse	on, Jr.					Mar	oh 26.	200C)	1:00 AIM		
Exam		4e. Facility Name (If not Institution, g.		() , (2.		or Location of Deal	th 4c. County	y of Deeth			
Funera		5. Social Security Number 6.		(In yrs. last bi	rthdey)	f Under 1 Year	If Under 24 I	Im cre	N/A	9. Birthp	elece (State or Foreign		
Director		216-42-7431 Usuel Residenca of Decedent	1 □MM 2 □ F	55	Yrs.	Aonths Days	Hours	Hrs. 8. Date of Bi fin. (Month, D Jul 1	2, 1944	9. Birthp Coun SC	try)		
arylan show		10e. Stete 10b. County		10c. City, Tow	n or Local	ion				1	Od. Inside City Limits		
the Maryla 28a-f shorn	cto	MD N/A		Balti	imore				1 ☐ Ye				
with the Maryland a or 28a-f show	Sire.	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?		
€ 8	<u>a</u>	1922 North Penro	se Avenue			21223			United	Stat	es		
20 after d or her	by Funeral Director	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorcad	12. Was Decedent E Armed Forces? 1 Yes 2 No. If Yes, Give Yeer or Detes:	THE STATE OF	If Y	s Decedent of les, specify Cub	an, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	Ble	ce - Americ ick, White, fy: ack			
15-00: 72 hours "netural",		15. Decedent's 8	ducation	16e	. Deceden	t's Usuei Occu	pation		16b. Kind of B	_	dustry		
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212 d withir glene. rr than	mo:	8	College (1-401 54		Laborer								
other vent, if		17. Fether's Name (First, Middle, Las	()				18. Mother's I	Name (First, Middle	, Melden Sumar	ne)			
Maryland d2 should be file th and Mental Hy 7 is marked other traumatic event	To E	Cleveland Wils	on, Sr.				Annie	Wilson					
Alary 2 sho 1 and N is me	-	19a. informent's Name/Relationship	(Type, Print)	198	o. Meiling	Address (Stree	t end Number of	Rural Route Numb	per, City or Town	, Stete, Zip	Code)		
1 and 2 Health a em 27 is		Mrs Annie Wilson	n - Mother	1	1922	North F	enrose	Avenue, I	Baltimor	e, MD	21223		
Baltimore, Noemit. Pages 1 and Department of Health important: If item 27 any Injury or other the page.		20e. Method of Disposition 1			ry, cremet	ory or other ple	Mar 29	20c. Location Baltin					
Baltimo		21. Signature of Funeral Service Licensee a Cuin 1. Ullumb Mount Zion Cemetery 1900 Baltimore, MD 22. Name and Address of Fecility Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore,											
		23a. Part I. Enter the disease, or cor shock, or heert failure. List only	nnlications that caused t	he death Do						LCTIIO	Approximate		
death certificate be executed e attending physician and ed for use as the burial-transit	Medical Examiner	Immediate Cause (Finel disease or condition resulting In death) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last	. Lun	Due to (or as a	consequence	sate	noc			C	One Mont		
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9		30. Neme and eddress of person who 2600 LiBER	completed ceuse of de	eth (item 23e)	(Type, Pri	11)	30	425 MO 3	21715				
St	ate	31. Date filed (Month, Dey, Year)	32. Registrer	's Signeture		- auti	- Mark	, WIU	-1213				
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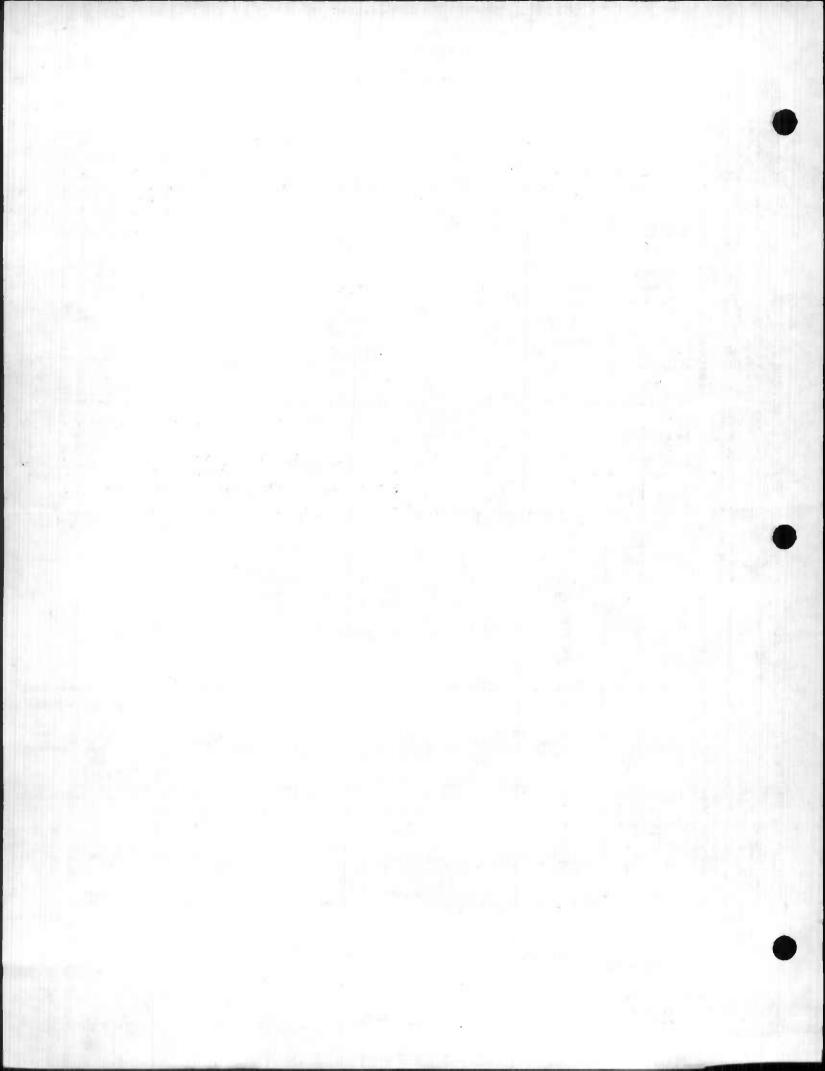
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene "Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Williams 22, 2000 Mar. 10:40am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Homewood Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-22-25 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1 M 283 F Yrs. Director 219-28-6465 N.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits show 1 X Yes 2 □ No Directo MD NA 28a-f Baltimore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 'natural', or hams 23s or must be 2014 Robb Street 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes ZONo Specify: 21215-0020 Specify: Black à 3 ₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) in own home NA Housewife Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fi through the part of the marked of fury or other traumatic ever 8 John Watson Lillie Towne 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Burley 2004 Robb Street Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any Injury or o to Burial 2 ☐ Cremetion 3 ☐ Removal from State King Mem. Pk. Cem. 03-28-2000 Randallstown, MD 22. Name and Address of Facility Baltimore, Maryland 21202 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licensee WM.C. March FH 1101 E. North Avenue 23a. Part-/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death Physician /Medical Immediate Cause (Final 4 perfension disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ementia physicien end s the burlei-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 pminsules dependent ratches medities Physician/Medical Due to (or as a consequence of) 88 for use as 980 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o \$ signed by t 1 Yes 250 3 Probably 4 Unknown م Records, þ cate has been sign, page 2 should b 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 Yes 250 1 ☐ Yes 2 ☐ No certificate Vitai director. Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To of this After this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division or Attending 5 Pending s efter death. investigation 1 Yes 2 No 2 Accident None 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 Homicide To the Hospital
within 24 hours a
To the Funeral C Hospital pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) marquente Imorano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Marquerite Moran, MD Union Mem. Professional Building Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2000 Registra oaks

C DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09898 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death March 23, 2000 5:30 PM Anna Catherine 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3017 E. Northern Parkway Baltimore If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Sept. 17,1913 If Under 1 Year 9. Birthplace (State or Foreign Country) Mary land 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□M 2\ F 86 215-09-0827 Yes Usual Rasidance of Decedant 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits Y Yas 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3017 E. Northern Parkway 21214 United States 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 1 ☐ Yas 2 X No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 10 Accountant Commercial Credit 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Boschert Anna M. Gunzelman Adam 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia A. Settar / Daughter 203 Burning Tree Road Timonium, MD 21093 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Gardens 3/27/00 Sykesville, Maryland 21. Signatura of Funary I Sarvice Licensep Timothy Harman 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) ereses Sequentielly list conditions, if any, laeding to immadiate causa. Entar Undarlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as e consequence of) eculiti Due to (or as a consequence of): Cenencia a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes No 1 Yes 2 No 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only one) 1 Yes 20 Ao Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28e. Deta of Injury (Month, Day Year) 27. Manner of Deeth 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1- Natural 5 Pending 1 Yes 2 No Invastigation 2 Accidant 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one)

68760 Box (P.O. Records, Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

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Certification: To

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DHMH 16 Rav 6/95

State Registrar

31. Data filed (Month, Day, Year) MAR 2 7 2000

29b. Signatura and titla of certifiar

€.33rd St. #265 32. Registrar's Signature

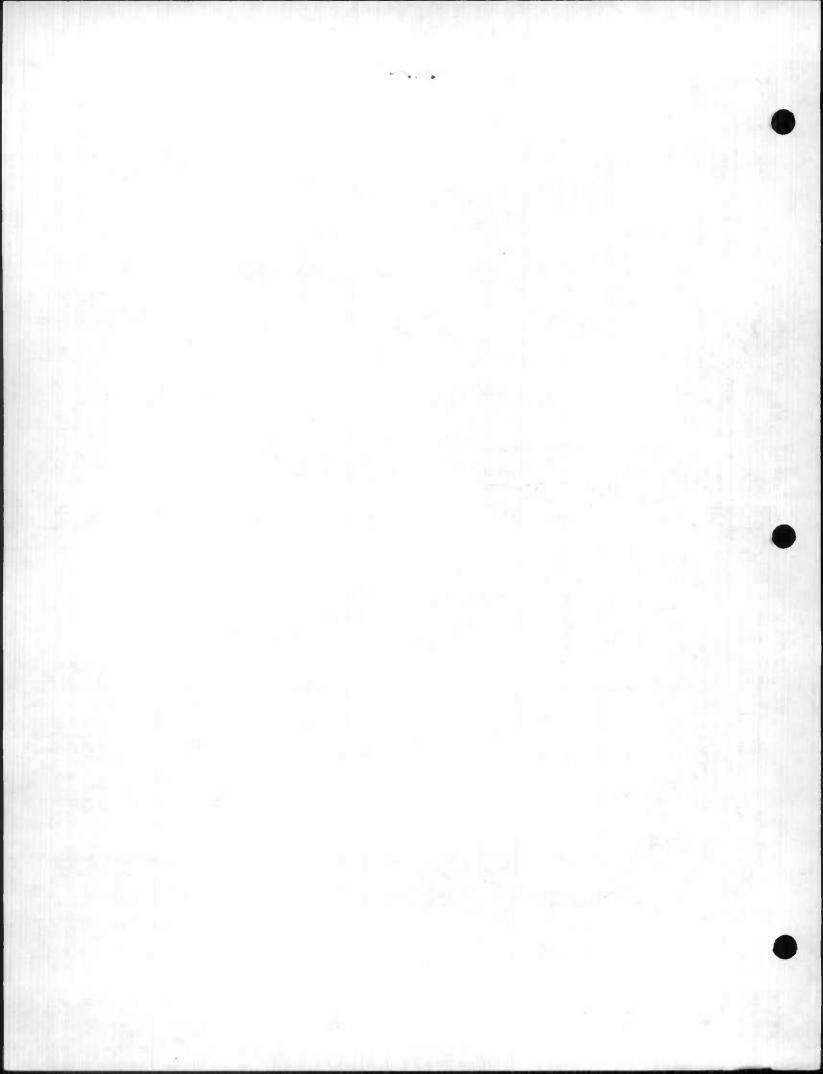
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

29d. Data signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03/24/2000 **Physician** Ellis James Womelsdorf 8:37pm /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 09/01/1930 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** Days Months Hours 18 M 2□ F 201-24-7009 69 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Anne Arundel Linthicum 28e-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? à 21090 238 507 LaClair Ave. United States Funeral 11 Marital Statue 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No / 17 / 1950 If Yes, Give 12 / 8 / 1953 1 ☐ Never Married 2 ☑ Merried 8 21215-0020 Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiana. 12 Mechanic Production Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Mae L. Howard Ellis A. Womelsdorf 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Iham 27 is or other tra Betty M. Womelsdorf/ wife 507 LaClair Ave. Linthicum, Maryland 21090 20b. Place of Disposition (Name of cometery, cremetery or other place)
MD Veterans—Crownsville 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 3/28/00 Crownsville, Maryland 4 Donation 5 □ Qther (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Baltimore, MD 23a. Part1. Enter the disease, or complications that Caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Atherosclerotic heart disease Examiner Due to (or es e consequence of) Examiner physician and the burial-trent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): The law requires that the death certificate be axecu Box 68760, Physician/Medical Due to (or es a consequence of): US0 08 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? certificate 2 0 No 1 ☐ Yes 2 ☐ No Attending Physicien: funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 DEFVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After Division 5 Pending investigation 1 Matural 1 Yes 2 No within 24 hours after deeth. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 6 Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Raymond Mitter 3/26/00 DA7683 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Khy mora Miller Sinte Main Street Beistestown 31. Dale filed (Month, Day, Year) 32. Registrar's Signeture State MAR 2 7 2000 Beneva

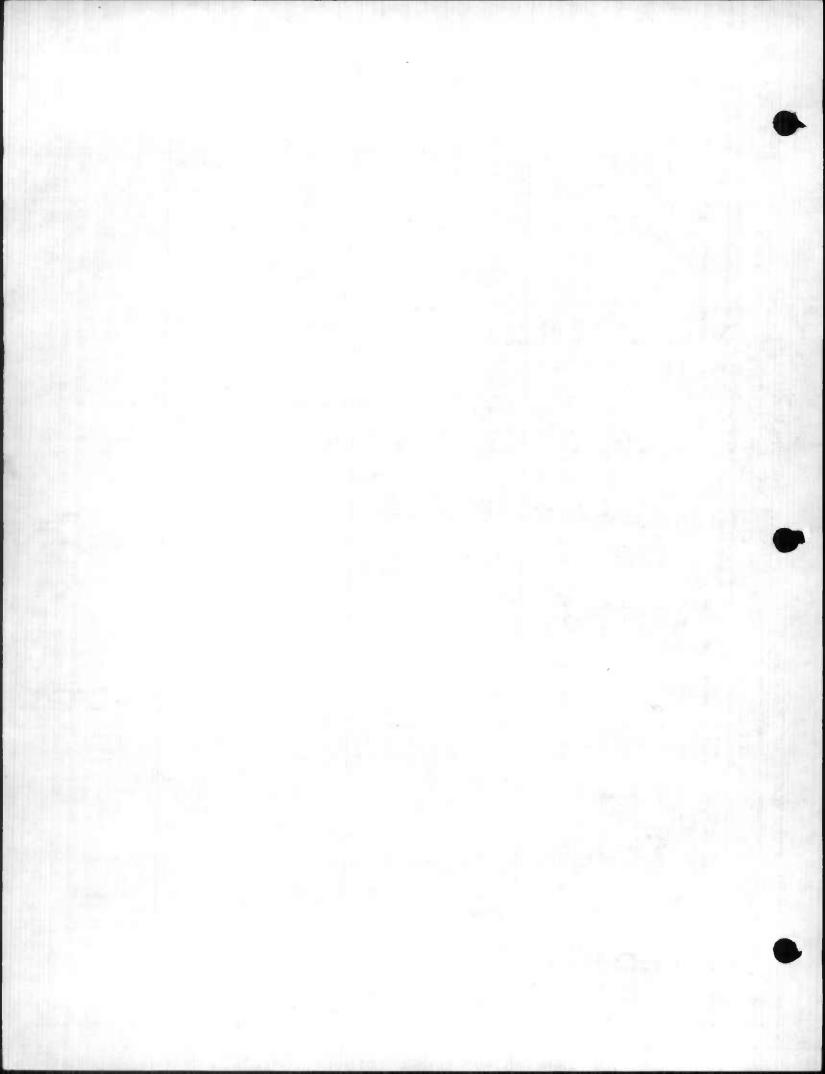
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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Harry Albright March 13, 2000 10:02am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moran Manor Nursing Home Westernport Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F 212-12-8627 99 Jan 8, Director 1901 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow ! 1 Yes 2 No Directo 28a-f Geauga Middlefield 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 23s or 5391 S. Windsor 44062 USA Funeral Barra . 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, etc. 1 Nevar Marriad 2 Married altimore, Maryland 21215-0020 "netural", or 1 ☐ Yes 2 ☐ No Specify: Specify: white à 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Heavy Equip Operator Farming permit. Pages 1 and 2 should be file.
Department of Health and Montal Hy
Important. If Nam 27 is marked oths
any injury or other traumatic event 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Albright Barbara (Owens) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 1 Box 169; Keyser WV 26726 19a. Informant's Name/Relationship (Type, Print) Violet Shreve daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pinto Mennonite Cemete3/16/ Pinto, MD 21. Signature of Funeral Servica Licansi Scarpedii Fulleral Home P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or comblications that caused the tenth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Cordiac Dysthy fluing Due to (or as a consequence of): disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 2 ge 1 Yes 254No 1 Yes 2 No certificate Division of Vital or Attanding Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 452Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 - Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiar (Check only one) 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) Es

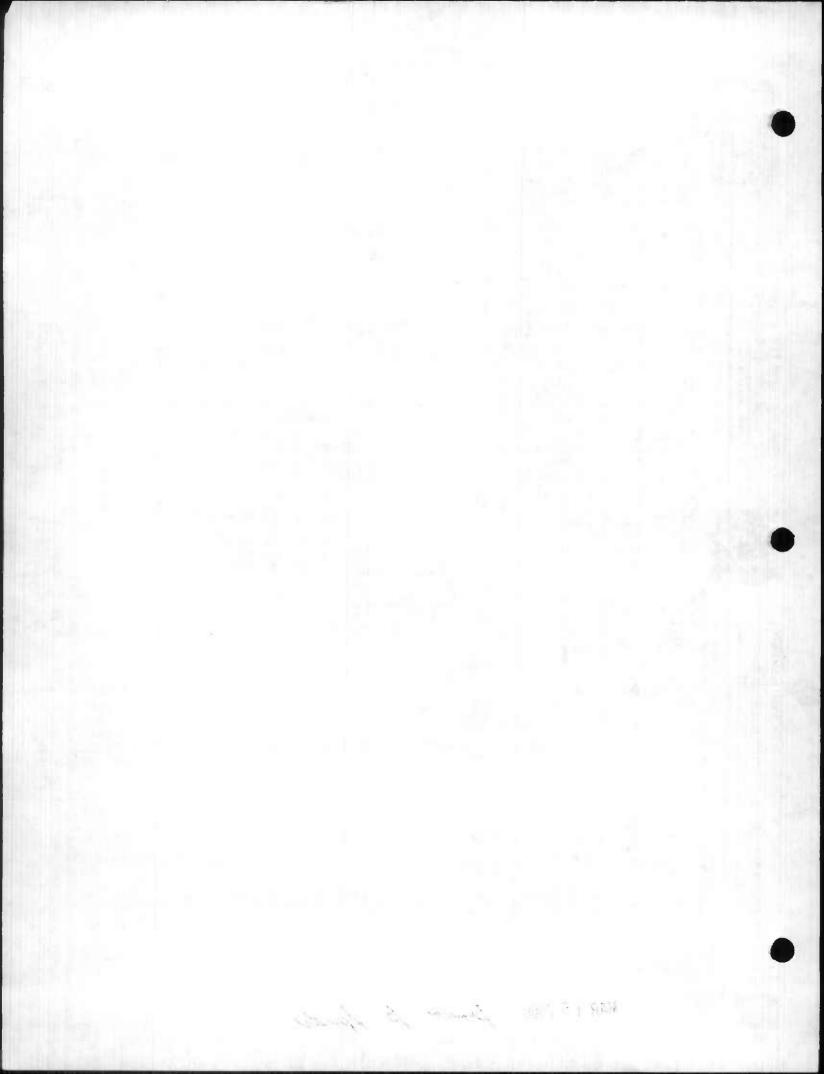
State Registrar

Jesus Tan, M.D.; Frostburg Plaza; Frostburg, MD 31. Date filed (Monte Par Year) 5 2000 32. Registrar's Signetura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D21244

March 14, 2000



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Leola Belle Burkett 7 2000 MARCH 3:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Allegany Cumberland If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2□F Yrs. 220 07 6269 88 3-22-1911 **Director** PA Usual Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No MD Allegany Cumberland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12110 Cash Valley Road, NE 21502 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yas 2 No If Yas, Give Year or Dates: 1 Navar Married 2 Married Saltimore, Maryland 21215-0020 Specify: White 1 Yas 2X No Specify: à 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health and Mental important: If flem 27 is marked of Lewis H. McKenzie Anna Steinly 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Route Number, City or Town, State, Zip Coda) William Burkett/Son 13217 Blank Road, Mount Savage, MD 20b. Ptace of Disposition (Name of cematary, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □X Buriat 2 □ Cramation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Lawn Memorial Gard. 3-11-00 LaVale, MD 21. Signature of Funaral Sarvice Licensee 22. Name and Addrass of Facility Harvey H. Zeigler Funeral Home, Hyndman, PA 23a. Part1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line Approximate Interval Between Onset and Death **Physician** tmmediate Causa (Final disaasa or condition resulting In death) /Medical ONE HOUR ACUTE PULMONARY EMBOLUS Examiner Due to (or as a consequence of) Examiner sician and buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequance of): certificate be execu ettending physician Box 68760 Physician/Medicai as the Due to (or as a consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? igned by 1 Yas 2 No 3 Probably 4 Unknown ACUTE BRONCHITIS Division of Vital Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? DEHYORATION has page 1 Yes 2 No 1 Yes 2 No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA edicai Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of ui or Attending P. s after death. i Director: After t 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mennar as stated.
2 Madfcal Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a Certifier 29c. Licanse number (Md) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8 MARCH 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) nes JAMES R. MOEN, MO 1068 NATIONAL HIGHWAY LAVALE, MO 21502

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State

Registrar

31. Data filed (Month, Dey, Year)

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32 Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1601 March 3, 2000 Dorothy Ellen Booth /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdev) **Funeral** 1 M 2 F Months Days Yrs. Director 220-52-7573 West Virginia 23-Jun-35 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Allegany Mount Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 13724 Lab Lane, N.W. Items 23a 21545-U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes, 2 10 No If Yes, Give T Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Merried Baltlmore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Hygiene. Eiementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 18 Mother's Name (First Middle Maiden Sumeme) 17. Father's Name (First, Middle, Last) 2 should be fi and Mentel H is marked off Be Russell Everett Carr Nina Estelle Swisher 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) of Health and them 27 is m Donald R. Booth, Sr. husband Mount Savage Maryland 21545-13724 Lab Lane, N.W. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata permit. Pages 1 Department of H Important: If Ner eny Injury or ott 1 Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 07-Mar-00 LaVale, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 John, 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner consequence of) Examin the bunel-transi Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque and Box 68760. attending physician Physician/Medical thet initiated events resulting in death) Last Due to for es a consequence of): 980 P.O. Part II. Other Manificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown yd bengis Records. à 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has page No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 8 25. Was case m 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 0 1 Yes 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? After t Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No ofter death 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In by 4 \ Homicide To the Hospital of within 24 hours of To the Funerel Dicompletely filled Is 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature and title of certifie 4 D un 2000 March

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State

Registrar

31. Date filed (Month, Day, Year)

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30. Nicolof R. Feilder, W.D., 923 Bishop Walsh Dive, Climberland, Maryland 21502

32. Registrar's Signature

Sorothy Ellen Poots

Maryland Allegany Mount Savage

13724 Lab Lane, N.W.

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Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PARKER WARDEN BREEDLOVE 6 2000 MARCH 8:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Months Days Hours Min Yrs. 95 VIRGIN 214-07-5826 9,1904 Director OCT Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yas 2 XNo ALLEGANY MARYLAND Directo CRESAPTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13106 WARRIOR DRIVE Нати 23а 21502 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) than "natural", or han Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ACETATE DEPT. WORKER FIBER 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 2 should be fit and Mental H I is marked off Be ROBERT E. LEE BREEDLOVE 2 ALMA JANE SELL 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health an Important: If New 27 is n any Injury or other traus MARIAN B. HITE/DAUGHTER P.O. BOX 5017, CRESAPTOWN, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MARCH 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) PLEASANT CEMETERY9,2000 CUMBERLAND, MD 22. Name and Address of Fecility
HAFER CHAPEL OF 21. Squature of Funeral Service Licenses THE HILLS MORTUARY 1302 NATIONAL HWY, bug LAVALE, MD 21502 23e. Pert1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical heumour Examiner Due to (or as a consequence of) Examiner physlma attending physician and for use as the bunal-transit certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. the à 1 Yea 2 No 3 Probably 4 Unknown Triorder i Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed has 1 ☐ Yes 2 ☐No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2€ No After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: s after death. 5 Pending Investigation 1 Naturat 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 T Homicide To the Hospital o within 24 hours af To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) 29b. Signature and file of certifier 29c. License number 29d, Date signed (Month, Dav. Year) Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Breza umberland 912 Seton Drive M.D. nus George 31. Date filed (Month, Day, Year) 32. Registrer's Signature State MAR 0 8 2000 Registrar

Survey of the Sales

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

09914' Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** Eugene Christner Bittner March 9, 2000 16:30 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Memorial Hospital Cumberland H Under 1 Year | H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months | Days | Houra | Min. | NOV 5 , 19(Birthplece (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** X□ M 2□ F 214-07-3616 90 Yrs. 1909 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "naturel", or itema 23s or 28s-f show with Injury or other traumatic event, the Medical Examine must be notified at once. 10c. City, Town or Location 10d. Inside City Limits X Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? id 44 Maple Street 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Biack, White, etc. X 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give WW II altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Retired Employee Brewery 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) George W. Bittner Sadie (Christner) 19a. Informant'a Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2 Box 244; Ridgeley Donna Jennings WV 26753 daughter 20a. Method of Disposition 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete cemetery, cremetory or other place) X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 3/13/ Cumberland, MD 21. Signature of Funeral Service Licenses Scarperii of Fulleral Home P.A. Cumberland, MD 21502 Approximate Interval Between Onset end Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only death. Do not enter the mode of dying, such es cardiac or respiretory arrest, **Physician** Immediate Cause (Finel disease or condition resulting In deeth) /Medical Renal Failure year **Examiner** Due to (or as a consequence of): Examiner sician and burial-transit Coronary Artery Disease unknown be executed Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as e consequence of): for use signed by the a Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco usa contributa to the causa of death? Records. P.O. 1 Yaa 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? should s 24e. Was en eutopsy performed? page 2 has 1 Yaa 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: director, Be 25. Was casa referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this funeral 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Netural 5 Pending 1 Yes 2 No To the Hospital or Attendivitin 24 hours after death.
To the Funeral Director: A completely filled in by the f death. 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and manner stated. Medicai 29a. Certifie (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certified March /0, 2000 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAD LaVale, MD Dr. Vik Poonai 920 National Highway 31. Date WAR 11 07. 2000 32. Registrar's Signature State Registrar

DHMH 16 Ray 6/95

The state of the s

Buckley

Certificate of Death

2. Data of Death

Month

March

4b. City, Town, or Location of Death

Day

1919

USA

2000

ALLEGANY

14 Race - American Indian Black, Whita, etc.

Specify: white

16h. Kind of Business/Industry

4c. County of Death

Birthplaca (State or Foreign Country)
 MD

10d. Inside City Limits X Yas 2 No

3. Tima of Deeth

3:00 A.M.

/Medic Examir	
Funeral Director	
se filed within 72 hours after death with the Maryland at Hygiens. I other than "natural", or items 23s or 28s-f show evert, the Medical Esamiret, must be notified at	Be Completed by Funeral Director

Physician

Erma

| CUMBERLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | Oct 17, 15 MEMORIAL HOSPITAL & MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) 10 M 20 F Yrs. 80 215-20-6782 **Usual Residence of Decedent** 10a State 10b. County 10c. City. Town or Location Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13910 Old Oldtown Road, SE 21502 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) College (1-4or 5+) Elementary/Secondary (0-12) The Millstone 12 Owner & Operator 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Harvey Nixon (Twigg) Anna permit. Pages 1 and 2 should Department of Health and Me Important: If Nem 27 is mark any Injury or other traumatis 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 16701 Harves Lane; Cumberland MD 21502 Aleasha Bishop Por Manda & Bishosition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Tabor Cemetery 3/12/ Spring Gap, MD 21. Signature of Funeral Service Licensee Scarpelli Funeral Home P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or compositions that caused the disease. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Cause (Final diseasa or condition resulting in death) Respiratory Arrest Examiner Due to (or es e consequence of): Examiner Congestive Heart Failure the death certificate be executed

Approximate Interval Between Onset and Death March 8 2000

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1. Decedent's Name (First, Middle, Last)

D.

4a Facility Name (If not institution, give street and number)

Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of)

Unknown

1 Yas 2 No

2000

21502

Unknown

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ventricular Ectophy, Leg Ulcers, Degenerative Joint

23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

Disease

24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed?

25. Was case referred to medical axaminer? 1 Yes 2 No

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred

27. Manner of Death 2 Accident 3 ☐ Suicide

4 ☐ Homicide

28a. Dete of tnjury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARCH

1 Yas 22 No

29e. Certifier (Check only one) The Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated.

29c. License number

29b. Signature and title of confiler

D 0054004

29d. Date signed (Month, Day, Year)

1265

france 1 30. Name and address of peson who completed cause of death (Nern 23a) (Type, Print) 625 Kent Avenue, Suite 101

DR. SHIV KHANNA, 31. Date filed (Month, Day, Year) MAR 1 0 2000

JOHNSON HEIGHTS MEDICAL BUILDING 32. Registrar's Signature

CUMBERLAND, MD

State Registrar

Box 68760.

P.O.

Records,

of Vital

215-20-6782

ERMA BUCKLEY

physician

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In Director: An.

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Attending F or death. Division

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Physician/Medical

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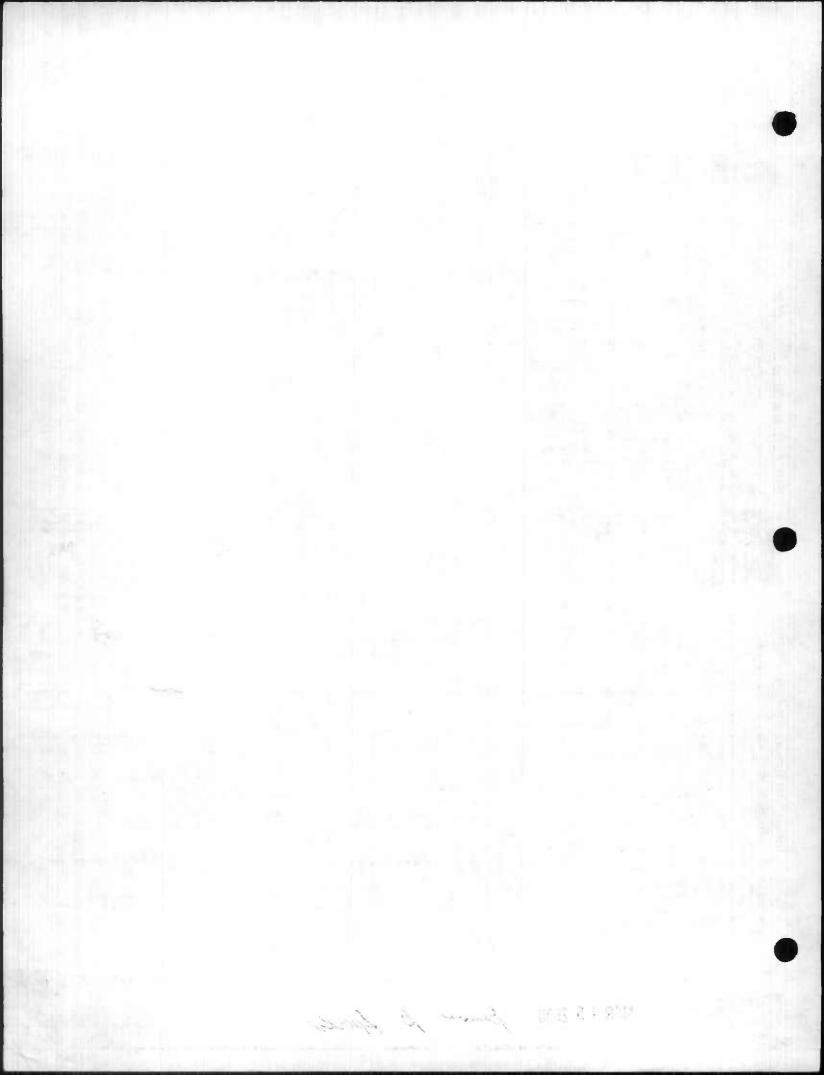
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2000 Month **Physician** 14, James Buckley Mar 04:15am /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll Hours Min. Aug 14, 1932 If Under 1 Year 5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months ★□ M 2□ F 048-22-3336 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits X □ Yes 2 □ No Directo Beaufort Hilton Head 288-7 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Name 23a or 4 Brassie Court 29928 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 14 Yes 2 □ No If Yes, Give Yaar or Deta Orea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. hours after 1 Never Merried 2 Married 8 21215-0020 1 Yes 2 No Specify: py Specifiwhite 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grads completed) 16b. Kind of Business/Industry be filed within 72 Elementery/Secondary (0-12) Hygiene. ther then College (1-4or 5+) Cumberland Times Advertising Director altimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) is marked of Louis Edward Buckley Mary E (McCarthy) Pages 1 and 2 should 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6040 Torrey Pines Dr; Mt. Airy, MD 21771 19a. tnforment's Neme/Reletionship (Type, Print) Francis B. Buckley Department of Health important: If Item 27 I 20a. Method of Disposition 20b. Plece of Disposition (Name of cematery, cremetory or other place) Date 20c. Location - City or Town, State 8 Buriel 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Joseph Cemetery 3/18/ Midland, MD 21. Signature of Funeral Ser Scarperri Funeral Home P.A. Cumberland, Maryland 21502 ns that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, use on each line. 23a. Part1. Enter the diseese, or complication shock, or heart feilura. List only one gas Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Ma WNG Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Due to (or as a consequence of): and Box 68760 attending physician Physician/Medicai the Due to (or as a consequence of): 080 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? 20 No 212 16 1 ☐ Yes 1 ☐ Yes this certificate Attending Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending death. 1 Tyes 2 No al or Attendil s after death. I Director: A of in by the fu investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of tnjury - At home, farm, street, fectory, office building, etc. (Specify) lilled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D Dentifying Phyalctan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier completely 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date syaned Month. Day, Year) W) 3 6 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) KRU PER WASHINGTON WESTMINSTER MUS 21157 MAULO 224 HGTI. 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

State

Registrar

MAR 1 5 2000



Physician/Medical à Completed Be To Certification:

Box 68760.

P.O.

Records,

Vital

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Division Attending certificate

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after death. Director: Al

24 hours Funeral

To the Comple

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Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. MICROCEPHALY, SEIZURE DISORDER, MENTAL RETARDATION

23b. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

March 17, 2000

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

21635 Approximete Interval Between Onset and Death

3. Time of Death

8:44 A.M.

10d. Inside City Limits

110 Yes 2 No

2 No

2 No

25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 🗹 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending

1☐Yes 2☐No investigetion 2 Accident

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier (Check only one)

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and afte of certifie

O.C.M.E. 30. Neme and address of person who completed cause of deeth (tern 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

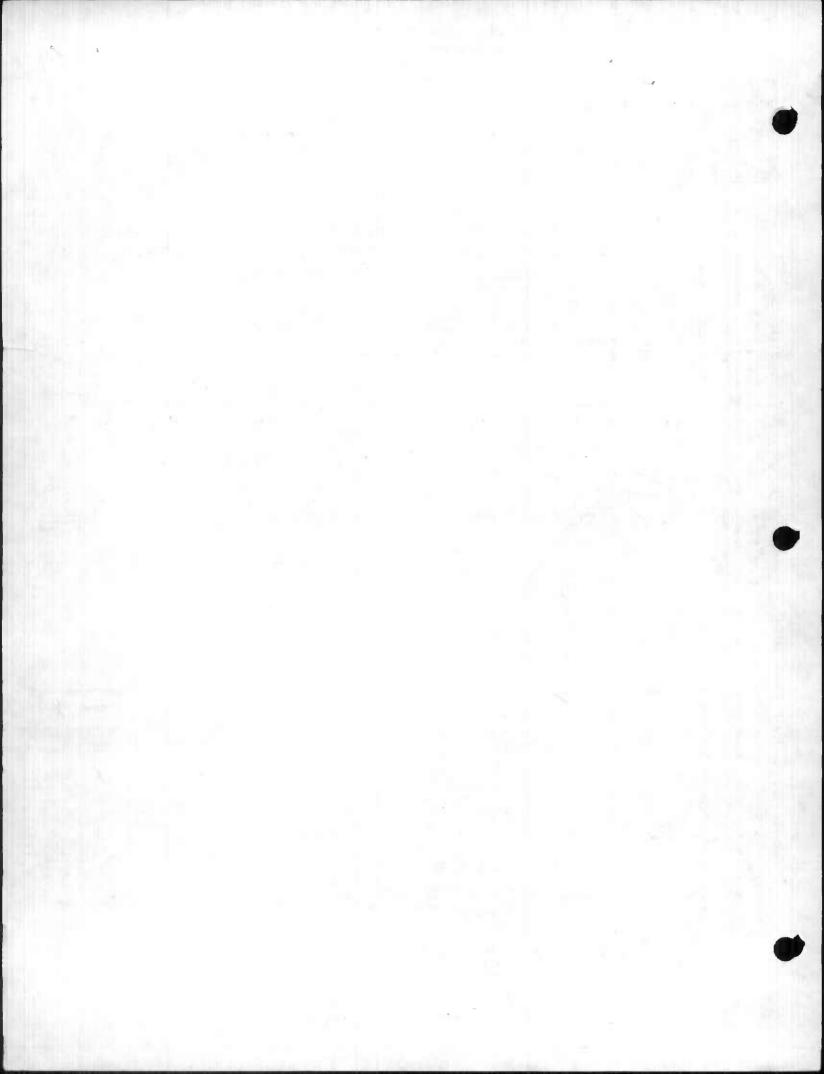
State Registrar

MAR 2 7 2000

HEODORE M. 14"

31. Dete tiled (Month, Day, Year)

Registravia Signature



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death COAKLEY, JR- FRIBITUAITY 28 2000 **Physician** JOSEPH 7:35A.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOSPITAL HOPKINS 13 ALTINONE N/A H Under 1 Year Munder 24 Hrs. 8. Dete of Birth Pey, Year)
Months Days Hours Min. Aug. 24, 1946 Massachusetts 6. Sex 10 M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 53 Director 212-50-1010 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes ZONO Directo 28a-f Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? therm 23a or intermediate in 1201 John Ross Court 21032 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11 Marital Status Black, White, etc. 1 Never Merried 2 Merried 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: 1968-74 il Hygiens. other than "natural", or the vent, the Medical Examin Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H tart; if them 27 is marked oth lary or other traumatic even Be Joseph Hanley Coakley, Sr. Anne Noone 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly A. Coakley/ Wife 1201 John Ross Court Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Denial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Resurrection Cemetery 3-3-00 Clinton, Maryland 22. Neme end Address of Fecility 21 Signature of Funeral Service Licenses George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical UPPER GASTROINTESTINAL BLEEDING 7 PAYS Examiner Due to (or as a consequenca of): Examiner PNIBUMONIA + DAYS sician and bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): physician is the bunal METASTASES Box 68760. CANCER WITH 4 41EARS ESOPHAGEAL Physician/Medical Due to (or es a consequence of): BONES BRAIN AND 080 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate 1 Yes 2 N No 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Was case reterred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4□ Nursing Home 5□ Residence 6□Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide filled in 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) FIERIZUARY 28 2000 P12592 30. Name and address of person vito completed cause of death (Item 23a) (Type, Print) MAKSY MILIAW CATON AUE BALTIMONE KAWALBE 900 31. Dete tiled (Month, Day, Year) 32 Registrar's Signature State

DHMH 16 Rsv 6/95

Registrar

MAR 0 1 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Yeer **Physician** DANIEL GLENWOOD EMMART 8, 2000 4c. County of Death /Medical March 10:15 am 4a Facility Neme (Il not institution, give street end number) 4b. City. Town, or Location of Deeth Examiner Memorial Hospital Cumberland
If Under 24 Hrs. Allegany 8. Dete of Birth (Month, Dey, Year) If Linder 1 Yea Birthpleca (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** r VIRGINIA Days Hours Months Min. 1♥ M 2□ F 72 Yrs NOV. 8,1927 WEST Director 213-24-6852 Usuel Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location r 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 No Director WV MINERAL RIDGELEY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? me 23a of death with ROUTE 2, BOX 657 26753 U.S.A. Funeral 14. Race - American Indian, Bieck, White, etc. or Nems 11. Meritei Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or iten filed within 72 hours after Never Merried 2☐ Merried 1 Yes 2 No 1 Yes 2 No Specify: WHITE '46 Specify: P 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry KELLY-SPRINGFIELD I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) DRAFTSMAN TIRE COMPANY . Pages 1 and 2 should be filed w iment of Health and Mental Hygier lant: if item 27 is marked other th jury or other traumatic avant, the 12 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be DANIEL P. EMMART STELLA M. BORROR 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 13523 ELLERSLIE RD., NW - CUMBERLAND, MD M. ETTA FRIDLEY / SISTER 21502 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery cremetory or other of Dete 20c. Location - City or Town, State cemetery, cremetory or other plece)
FORT ASHBY CEMETERY 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any Injury or page. 3/12/00 FORT ASHBY, WV 21. Signeture of Funerei Service Licenses 22. Name end Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel 1/00 Metastatic Non-Small Cell Carcinoma of Lung diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or es a consequence of): Physician/Medical the Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 3 Probably 4 Unknown 1 Yes 2 No signed be del Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 certificate 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 M Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No death. 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner steted.

Box 68760. P.O. Records, of Vital or Attending Physician: Division 24 hours a Funeral C Hospital Medical completely To the To the To the I

21215-0020

Baltimore, Maryland

nus

Registrar

Dr. Qamar U Zaman Johnson Heights Medical Bldg. 625 Kent Avenue Suite 102 Cumberland 31. Dete filed (Month, Dey, Year)
MAR 1 3 2000 State

29b. Signamin and like of cartifier

32. Registrar's Signeture

amon

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

29c. License number

D0023371

29d. Dete signed (Month, Dey, Year) March 13, 2000

Secretary of the second

Amended #20b, NLS, 3/9/00, Allegany Co. Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9 9 1 0

State of Maryland / Department of Health and Mental Hygiene	е

				Cel	tificate of	Death			Reg. No.				
Physician	1. Decedent's Name (First, Middle, Last) EMMA JANE ANNE FULKERSON							2. Dete of Death Month Dey Year MARCH 6 2000					
/Medical Examiner	4a Facility Name (If not institu	MARCH 6, 2900 0150 A 4b. City, Town, or Location of Death 4c. County of Death											
	Sacred	Heart Hosp	ital		H	Cumbe	erlar	and Allegany					
Funeral	5. Sociel Security Number	6. Sex	7. Age (In yrs. last		If Under 1 Yea Months Dey		24 Hrs. Min.	8. Dete of Bi	12,1945		ece (State or Foreign		
Director	307-46-6519 1 X 7 34 Yrs.								12,1945	Ind:	iana		
pu .	Usual Residence of Decedent 10e. State 10b. Cou		10c. City, T	own or Lo	cation			-		11	Od. Inside City Limits		
death with the Maryland rns 23a or 28a-f show Linus be notified at ner all Director	WV Hampshire Burlington 10e. Street and Number 10f. Zip Code								1 ☐ Yes 2 No				
Office death with the Marite death with the Marite and 28a-f-existe must be notified Funeral Director	10e. Street and Number Rt. 2, Box 44 C 26710								10g. Citizen of What Country? U.S.A.				
	11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexicen, Puerto							ecify Yes or No- Rican, etc.) 14. Race - American Indian, Bleck, White, etc.					
D2 ones	3 ☐ Widowed 4 ☐ Divorced Year or Dates:								Specify	Whi	te		
2121 d within piene. r than	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) 12th 15a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Laborer							ing	Poultry Food Company				
Maryland 2 d 2 should be filed th and Mental Hygil traumatic event, a	17. Father's Neme (First, Mide Charles L.							Marie	, <i>Maiden Sum</i> en Flora	ne)			
C T N L	19e. Informent's Neme/Relati				ng Address (Stre				per, City or Town, WV 2	State, Zip 6 71 0	Code)		
Baltimore, semit. Peges 1 an Department of Heel moortant: if item 2 iny injury or other Miss.	20e. Method of Disposition 1 Buriei 2 The Cremetion 3 Removal from State 4 Donetton, 5 Other (Specify) 20b. Piece of Disposition (Name of cametery, cremetory or other place) Scarpelliæ Funeral Home 20c. Location - City or To cametery, cremetory or other place) Scarpelliæ Funeral Home									wn, State MD			
Balti permit. Departm Importar any Inju	21. Squature of Appera Service Licensee 22. Name and Address of Facility 230 East Maiin St. Shaffer Funeral Home Romney, WV 26757												
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DI To the Heapital or within 24 horses of To the Funeral pitt completely lilled in Medical Cert	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner es steted. (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner steted. Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner es steted. Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner es steted.												
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ns	30 Negre and address of pers	son who completed ceu	ise of death (thirt 2)	Sa) (Type,	Print)	Vimb.	oda	al M	MARCI		2000		
State Registrar	31. Deta Wad (Month, Dey, You MAR 0 9 20	9ar) 32.1	Registrer's Signatur	B	book	unp	TUI	10	a del	30			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth James Fisher 9, 05:50pm 2000 Mar. 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Allegany County Nursing Home Cumberland Allegany | House 1 Year | House 24 Hrs. | 8. Date of Birth (Months Days Hours | Min. Jun. 23, 1910 5. Sociel Security Number 705 - 09 - 9639 Birthplace (Stete or Foreign Country) MD 7. Age (In yrs. lest birthdey) Months X1 M 2 F 89 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits X1 Yes 2 No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Glenmore Street 21502 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes Y ☐ No Specify: Specifywhite 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 Elementary/Secondary (0-12) College (1-4or 5+) Retired Laborer Railroad 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) James H. Fisher Amanda M Herrick Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Glenmore Street; Cumberland MD 21502 19a. Informent's Nema/Reletionship (Type, Print) Laura K. Fisher 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from Stete 20b. Piace of Disposition (Neme of cametery, cremetory or other plece) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 3/11/ Cumberland, MD 21. Signature of Funeral Service Licensee SeamperAdes Futteral Home P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. onot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediete Ceuse (Finel disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequença of) Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown reimer 24b. Were eutopsy findings evellable prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification:

edicai pletely

27. Manner of Death

1 Natural

29a. Certifier

(Check only one)

Physician

/Medical

Examiner

Director

than "natural", or items 23a or 28a-f show the Medical Examiner mant be notified at

"natural", or

permit. Pages 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natu any injury or other traumatic event, its is income.

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72 hours after death

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requires that the death certificate be executed Box 68760. P.O. The law r Division of Vital Physician: or Attending death. n 24 hours after death.

Funeral Director: A pletely filled in by the fi

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2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

5 Pending Investigation

28e. Date of Injury (Month, Dey Year)

28h Time of

1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

21502

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner as atlated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of Kanyı 29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

V.A. Ranjithan, M.D.; Furnace Street Ext.; Cumberland, MD

31. Dete filed (Month, Dey, Year) MAR 1 0 2000 32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene

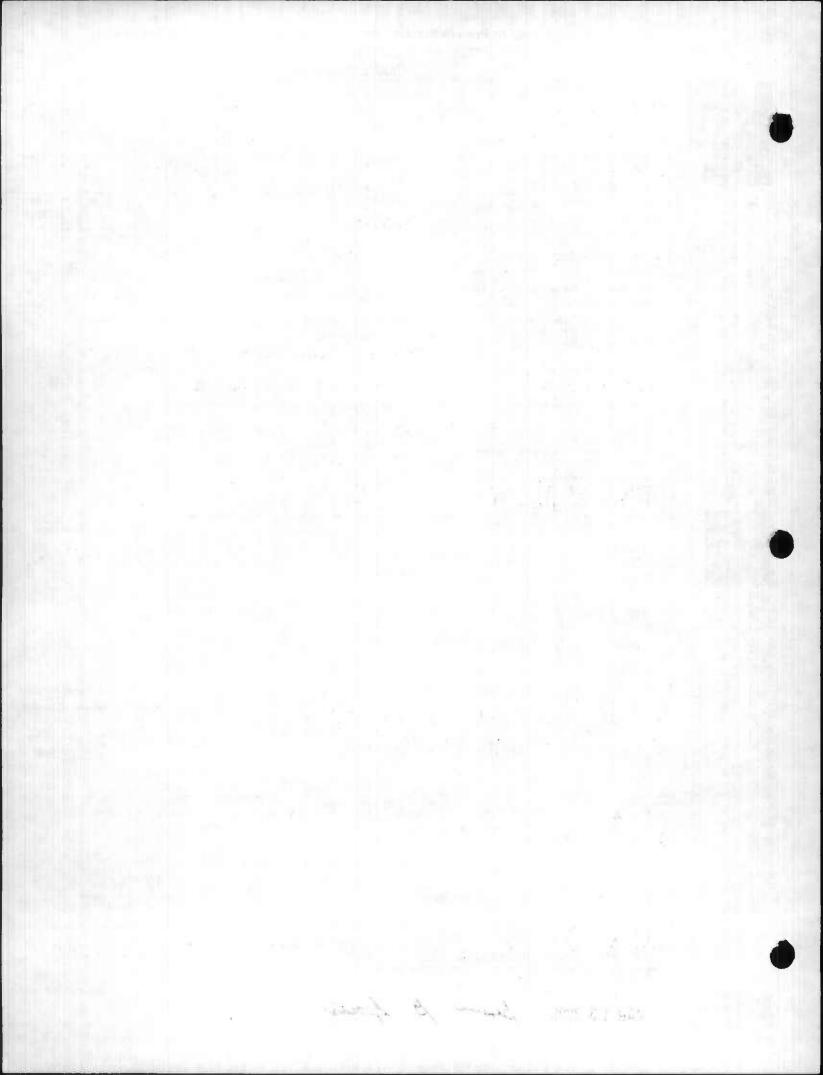
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uneral irector									Min.	8. Dale of Birth (Month, Day, Year) JAN 18 1915 MARYLAND				
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To	JOHNST	ON GRAH	AME					AL	ICE I	HERGOTT				
E	19a. Informant's	Name/Relations	hlp (Type, Print)		19b. Maili	ng Address	(Stree	et end Numb	er or Rur	rei Route Numb	er, City or Town	, State, Z	ip Code)	
other traumatic event, the M. To Be Comp	MARY RI		S	ISTER		RIDGE		AD L	AVAL	E MARYL		502		
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dical Cert	29a. Certifier (Check only one)		g Physician: To the Examiner: On the b	asis of examina										
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AN 517 OLDTOWN ROAD CUMBERLAND MARYLAND
32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

DR VTM A A RAN.
31. Date filed (Month, Dey, Year)
MAR 1 3 2000



Amended #31, NLS, 3/13/00, Allegany Co.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death Dey 2000 Month Physician March 4, 11:59 pm Haselberger Joseph Paul /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Memorial Hospital **Cumberland** Allegany | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Apr 24, 1914 9. Birthplace (State or Foreign If Under 1 5. Sociel Security Number 7. Age (In yrs. last birthday) X M 20 F **Funeral** Months Days MĎ 85 Director 214-05-6419 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fahon the Medical Examiner must be nothed at XI Yes 2 No Director Allegany Cumberland MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 USA 21502 Norma 23a 406 Memorial Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Ž No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Meritel Stetus permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiane. Important: If item 27 is merked other than "insturel", or free page. Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Joe's Food Market 12 Owner/operator 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Mary A (McKenna) Joseph Haselberger 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Margaret Thomas P.O. Box 2282; Cumberland MD 21502 da Want of Bisposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stete X Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/08/ Cumberland, MD Mary's Cemetery 21. Signature of Funeral Service License Scarpelli Fulleral Home P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Immediate Cause (Finel diseasa or condition resulting in death) /Medical 2 hours Acute Myocardial Infarction Examine Due to (or as a consequence of) Examiner physicien and the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or as e consequence of) 180 P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 s 800 1 Yes ZONO 1 Yes 2 No Vital 25. Wes case reterred to medical axaminer? director Be 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA Certification: To 1 Inpatient of this 28d. Describe how injury occurred 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? i or Attending F Affer Division 1 Neturel
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Direct completely filled in by 4 Homicide edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of could D 22181 March 10, 2000 30. Name and address of purion who completed cause of death (Item 23a) (Type, Print) mis Gary L. Wagoner 925 Bishop Walsh Road Cumberland MD 21502 32. Registrar's Signa State

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Registrar

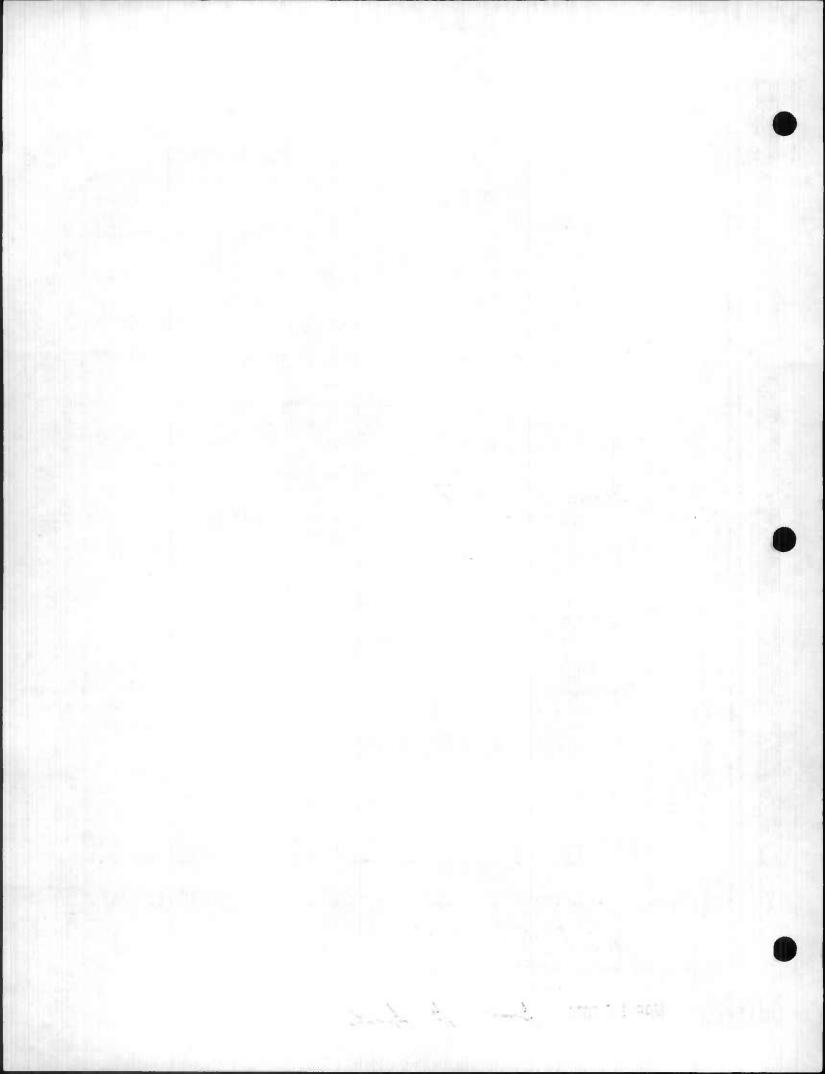
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State of Maryland / Department of Health and Mental Hygiene 0 0 9 9 4

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Funeral	5. Social Security	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un						If Under 24 Hrs Hours Min	8. Date of Bi	8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country)			
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Page 2									10	Yes 20 No		□Yes 2□No	
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fune	1 R Natural 2 Accident	5 Pending Investigation	(Month, Da	lay Year)	Injury	М		rk? Yes 2∐No					
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Me	29b. Signature a	nd title of certifier	A			29	C. Licens	se number		29d. Date sign	ed (Month,	Dey, Year)	
3		N.H.Ka	illes				D101						
	30 Name and a	D1931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								raic	11/4	, 2000	
M							7 1.	l	m 2150	2			
	Dr. N. 31. Date tiled (M	A. Ranjit		ULGEO trar's Signa	wn Roa) D1	Jumbe	erland, N	D 2150	4			
State Registrar	MAR	1 7 2000	Rend	La Colgri	4	100.	1,						

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month Year **Physician** March 06, 2000 5:00 a.m. Lee R Jones /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year 8. Date of Birth (Month, Dev. Yo Jun 19, If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) **Funeral** Year) 1918 Months Deys Hours 1 M 2□ F 220-10-8678 81 Yrs. Director Usuai Residence of Decedent the Maryland 10a State 10d. Inside City Limits or 28a-f show a notified at 10b. County 10c. City. Town or Location 1 √ Yes 2 No Director Allegany Cumberland MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene.
7 is marked other than "natural", or items 23s or treumstic event, the Medical Exeminant must be a 706 Oldtown Road 21502 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ Ho
If Yes, Give
Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien Bleck, White, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Tes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Elementery/Secondery (0-12) College (1-4or 5+) retired mechanic Construction Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt ment of Health and Mental Hiant: If Item 27 is marked oth jury or other treumstic even Robert Jones Ida (Grove) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7.06 Oldtown Road; Cumberland MD 21502 19a, Informent's Neme/Reletionship (Type, Print) Eva Jones 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriei 2 Cremetion 3 Removel from Stete Department of Important: If eny injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrest Memorial Par3/08/ Cumberland, MD 21. Signetyre of Funerel Service Licansee 22 Scarpers of Faritineral Home P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) PNEUMONIA 5 DAYS Examiner Due to (or es e consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE 5 YEARS ician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) physician the burie Box 68760. **Physician/Medical** Due to (or es e consequença of) 88 USB P.O. 23b. Did tobaceo use contributs to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 Yes 2 PINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA After this funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Division or Attending 1 Netural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 112 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 29b. Signeture and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) 10 D16041 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Terry Williams, M.D., Memorial Hospital Medical Building Cumberland, Maryland 21502 134 31. Dete filed (MAR Day) 32. Pagistrer's Signeture

DHMH 16 Rev 6/95

State Registrar

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+	Decedent's Nama (First, Middle	e, Last)		Cel	rtificate c	i Dea	ın ·	2. Date of De	Reg. No.		3. Time of Death				
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neral ector	5. Social Security Number 216 22 5301	6. Sex XXM 2□ F	7. Age (In yrs. 72	last birthday) If Under 1 Year If Under 1 Year Months Days Hours			der 24 Hrs. rs Min.	8. Dete of Bi (Month, D			olaca (State or Foreign				
31	Usual Residence of Decedent		12					APRIL	1 1927	MARY	LAND				
Funeral Director	10a. Stata 10b. County		10c. City, Town or Location							10d. Inside City Limits					
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8	17. Father's Name (First, Middle,								e, Maiden Suma	me)					
70	R. FRANK LEWIS		e Print) 10h Mailin				SIE S			or Town State Zio Code)					
	19e. Informent's Name/Relationsh VIRGINIA LEWIS		19b. Meiling Address (Street and Number of 148 WASHINGTON STREET												
	20a. Method of Disposition			Place of Dispo	sition (Name of		İ	Data 20c. Location - City or							
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) FROSTBURG MEMORIAL PARK 3/10/0									/00 FROSTBURG, MD					
	21. Signature of Funeral Service I	Licensee				21. Signature of Funeral Service Licensee 22. Nama and Address of Facility SOWERS FUNERAL HOME, P.A.									
	Para)														
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart lailura. List only one cause on each line.														
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Registrar

Dr. Vik Poonai 920 National Highway LaVale, MD 21502

State
gistrar

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State
gistrar's Signeture

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Red. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 2000 MARCH 19:20 6 ARTHUR REGINALD MARTIN 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY | Months | Days | Hours | Min. | No. | Hours | Min. | OCT 24 1918 6. Sex 1 → M 2 → F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Months 214-07-5127 81 W. VA. Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ALLEGANY CUMBERLAND 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15421 BOTTLE RUN ROAD N.E. 21502 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Merital Status Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1944-1946 Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No Specify: WHITE Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CONTRACTOR CONTRACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) LYDIA DeVORE REGINALD SHANNON MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY MARTIN WIFE 15421 BOTTLE RUN ROAD N.E. CUMBERLAND MARYLAND 21502 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State ROCKY GAP VET CEMETERY MARCH 9 2000 RFD FLINTSTONE MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Facility le MERRITT-ADAMS FUNERAL HOLLS 404 DECATUR STREET CUMBERLAND MARYLAND Approximate Interval Between Onset and Death MERRITT-ADAMS FUNERAL HOME P.A. di 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolism March 4, 2000 Due to (or as a consequence of) Deep Venous Thrombosis Unknown Due to (or as a consequence of): Status post surgery (hip) 13 days Due to (or as e consequenca of): Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 | Yea 2 | No 3 | Probably 4 Unknown Chronic obstructive pulmonary disease, coronary 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? artery disease, hypertension completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending investigation

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

notified at

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72 hours after

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Pages 1 and 2 should be nant of Health and Mental

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= 8 Department of important: If any injury or

Saltimore, Maryland 21215-0020

Director

Funeral

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Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical the USB 88 Š Completed

3 ☐ Suicide

29a. Certifie

4 ☐ Homicide

(Check only one)

signed by t has certificata Be Certification: To this funeral After 3

The law requires that the death certificate be executed

or Attending Physician:

Hospital

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Box 68760.

P.O.

of Vital Records.

Division

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completely within 2. To the F

Ms

State

Registrar

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and inter of compliant

6 ☐ Could not be determined

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

marina.

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 29d. Date signed (Month, Day, Year)

D0054004

MARCH & 2000

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNSON HEIGHTS MEDICAL BLDG., 625 KENT AVE., CUMBERLAND, MD SHIV C. KHANNA, MD, 31. Date filed (Month, Dey, Year)

MAR 0 8 2000

32. Registrar's Signature

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THE RESIDENCE SAME SAME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Year E, MABEL MANGES 03 1:45 pm 2000 /Medicai 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Egie Nursing Home Allegany Longconing 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□M 2⊠F Days 81 Yrs. 214-05-9825 Director 05-Nov-18 Maryland Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland **Allegany** Frostburg 10e. Street and Number 41 Green Street 10f. Zip Code 10g. Citizen of Whet Country? 21532-U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after in ent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or ite t ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1□ Yes 2 No Specify: À Specifyite 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) William Walker 2 **Edith Adams** 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Fram Grandson P.O. Box 814 Grantsville Maryland 21563-20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 6 permit. Page Depertment of Important: If any Injury or once. Frostburg Memoriai Park 4 ☐ Donetion 5 ☐ Other (Specify) 07-Mar-00 Frostburg, Maryland 21. Signature of Funeral Service Ligan 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 open 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finat Core bral Vescular accident 7 days disease or condition resulting in deeth) Examiner Examiner requires that the death certificate be executed the buriel-transit pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Due to (or as a consequence of): use as ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown Mellitus 1 ☐ Yes 2 ☐ No p Dementia - alykeiner's Type 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed peen certificata has t director, pege 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical exeminer?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f, Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m March 6, 2000 D07004

21539

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L.R. MILES, JR.

MAR 0 8 2000

31. Date filed (Month, Dey, Year)

M.D.

32. Registrar's Signature

57 JACKSON

ST. LONACONING

DHMH 16 Rev 6/95

Egia Nursing Home Street P.C. 80: 814 October 1907

William Walker Edith Adams

From as Iram Scardsco P.C. 80: 814 October Maryland \$1303-1804

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Durst Funeral Home, 57 Frost Ave., Frostburn, MD 21532

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	5. Social Security 494-28		Sex 7. A 1□ M 2√ F	ge (In yrs. last bi 87		Onths I		If Under 24 Hours	Hrs. Min.	8. Dete of Bio (Month, Di Feb 6	The Tolar	9. Birthy Cou	place (Stete or Foreign
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ninetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) 29c. License number 29d. Dete signed (Month, Dey, Year) 013601 MARCH 5

d ceuse of death (Item 23a) (Type, Print)

FACP 925 Brshop Walsh Rd Cumberland MD

State Registrar

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31. Date filed (Month, Dey, Year)
MAR 0 7 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			State of Marylar	nd / Department of Certificate of		Mental Hygie	00	09920				
	5	1. Decedent's Name (First, Middle, Las	1)	11 (51 31 g) 1 - 34		2. Date of Death	Day Year	3. Time of Death				
	Physician /Medical	ALLEN R. MILLER				MARCH	8 2000	2:15 PM				
1	Examiner	4a Facility Name (If not institution, give		ocation of Death	ath							
		Sacred Heart Hosp 5. Social Security Number 6. Se	nd B Date of Birth	Allega								
	Funeral Director	205 30 6300	8. Date of Birth (Month, Day, Ye 12~11 → 19	y Year) 1909 9. Birthplace (State or Foreign Country) PA								
ykand	B 18	10a. State 10b. County	10c. Cit	ty, Town or Location			10d. Inside City Limits					
e Mar	illed titled ctor	PA Bedford	But	falo Mills				1 ☐ Yes 2 💢 No				
6	be notified Director	10e. Street and Number	2 1	10f. Zip Cod			Citizen of What C	Country?				
- 6	a 23a	3145 Milligans Co	12. Was Decedent Ever in U	155			USA	nerican Indian.				
21215-0020 d within 72 hours after do	Examiner. By Fun	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ff Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puerto No Specify:	Rican, etc.)	Black, Wh	nile, etc.				
25.0	dical dical	15. Decedent's Edi (Specify only highest grad	ucetion fe completed)	16a. Decedent's Usuel Oc	cupation	ing 16t	o. Kind of Busines	s/Industry				
121	return 'natura', the Medical. Completed	Elementery/Secondary (0-12)	College (1-4or 5+)		ne during most of work ired)							
	Co Co	17. Father's Name (First, Middle, Last)	1	Dairy Farme		e (First, Middle, Mai	Agricult	we				
an an	kad ott	Oscar (mnu) Mille	P.Jr.			(mnu) Ho						
aryland	mark ument	19a. informant's Neme/Relationship (7		19b. Meiling Address (Str.				, Zip Code)				
N 2	n 27 is	John Miller/Son		3145 Millig								
Ore t	or all and and and and and and and and and and	20a. Method of Disposition 1008urial 2 Cremation 3		Place of Disposition (Neme of cemetery, cremetory or other in	olace)	Date 200	c. Location - City o	or Town, State				
altimore	tant:	4 Donation 5 Other (Specify	Mil	Eligans Cove C		-11-00 B	uffalo M	ills, PA				
Bai	mpor any in	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Harvey H. Zeigler Funeral Home, Hyp										
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Ex	aminer	disease or condition resulting in death)	a. Due to/(
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	as the	resulting in death) Last	Due to (d	or as a consequence of):								
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Geat	d by the attending phetached for use as the Physician/Med	Part If. Other aignificant conditions co	ntributing to death but not res	sulting in the underlying ceuse	given in Part I.	23b. Did toba	cco uss contribu	its to the causs of death?				
ords, P.O. Box 68 requires that the death certifical	ed by the attending physidetached for use as the // Physician/Medic	Doleyd	verteure :			1 Yes	2 No 3 🗆	Probably 4 Unknown				
Records,	should be det					24a. Was an a	utopsy 24t	o. Were autopsy findings				
law req	should be					performed	37	available prior to completion of cause of death?				
	page 2 should					1 ☐ Yes	20 No	1 Yes 2 No				
	s certificate hadirector, page	25. Was case referred to medicel examiner?			26. Place of Dea	th (Check only one)						
	To I	1 Yes 2 No		ER/Outpatient 3□ DOA		ome 5 Residenc		pecity)				
DIVISION OF or Attending Phy	After t lunera lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Dete of Injury (Month, Day Year)		njury at Nork? I ☐ Yes 2 ☐ No	28d. Describe how	injury occurred					
VISION	ctor: A y the fi	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, street, factory, offi		28f. Location (Stree	et end Number or	Rural Route Number,				
DIV.	as after death. al Director: After t led in by the funer: Certification:	4 Homicide determined	building, etc. (Special			City or Town, 5						
Hospita	within 24 bours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	stotan: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurred at the	e time, date and plece, by opinion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)				
o the	Nithin Fo the	29b. Signature and title of cediffer		29c. Lic	ense number	29d.	. Date signed (Mo	onth, Day, Year)				
	/	1 dan	ceine u	1 2	0 837	7 Ma	rch9 - 1	90				
	nus	30. Name and address of parson who c	ompleted cause of death (Iter	m 23a) (Type, Print)		/	4					
		Uriel Velando	M.D. 402	Seton Dri	re Cume	berland	MD	21502				
	State	31. Dete tiled (Month, Day, Year)	62. Registrar's Signa	aturg /								

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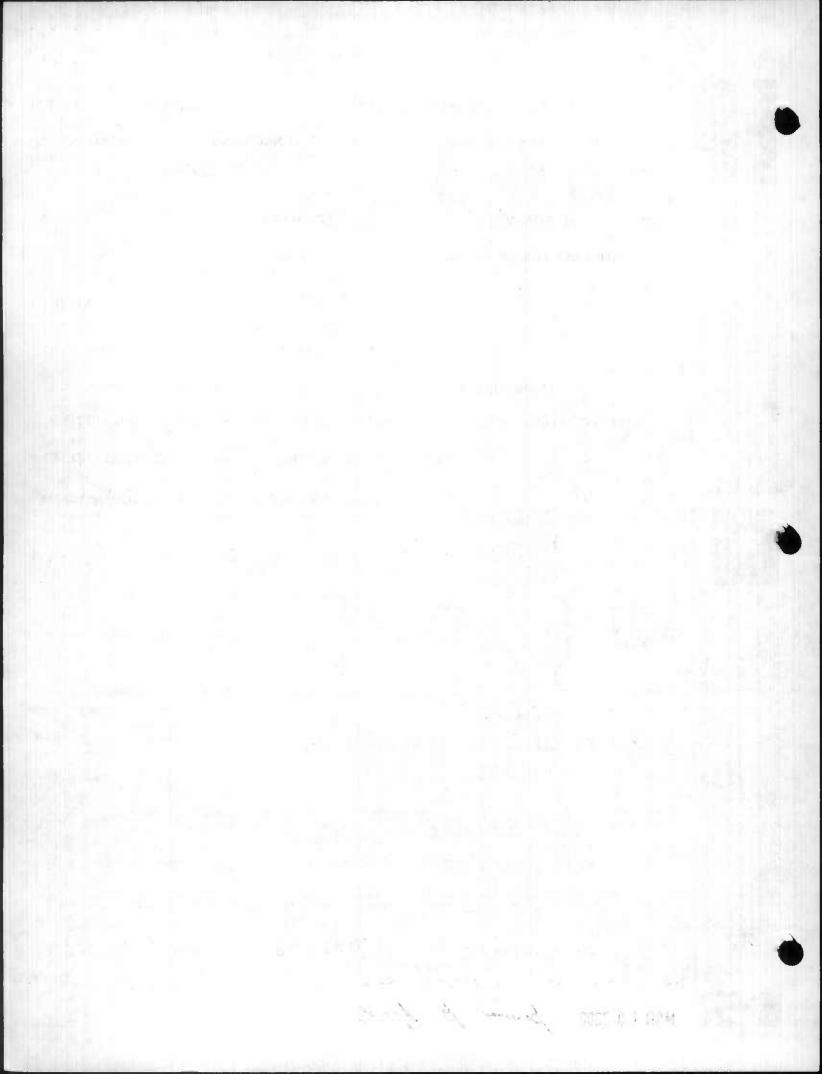
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month March 09, 2000 Year **Physician** 2:30 PM FRANKLIN ELLSWORTH MILLER SR. /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner LONACONING **ALLEGANY** 16116 BUCKS HILL ROAD, SW 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 ATD 7. Age (In yrs. lest birthday) Funeral 8. Date of Birth (Month, Dey, Yeer) 1 MM 2□ F Months Days Hours Yrs. MD June 09, 1925 Director 212-24-1584 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Director LONACONING **ALLEGANY** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 16116 BUCKS HILL ROAD, SW 21539 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 NoW W II If Yes, Give Year or Dates: U.S Army Herns 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indian. The Medical Examiner Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 ò 1 ☐ Yes 2 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) **PAPER** LABOR other 1 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be Department of Health and Mental I Important: If Item 27 is marked or any Injury or other traumatic eve MARTHA DAWSON FRANK MILLER 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 16116 BUCKS HILL ROAD, SW, LONACONING, MD 21539 MADELINE MILLER WIFF 20b. Place of Disposition (Name of cametery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) March 13. CUMBERLAND, MD SUNSET MEMORIAL PARK 2000 21. Signature of Funerai Servica Licansee 22. Name and Address of Facility yn Kengi ances & Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Prostate Carring with metastass Immediate Cause (Final (montes disease or condition resulting in deeth) **Examiner** Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last and the burial-tran Due to (or es e consequenca of): Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical Due to (or as a consequence of) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? eabete mellitys 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, p Left Renal Carrinenia with Left Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No certificata 1 ☐ Yes 2 ☐ No or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2 No Other: 4 Nursing Home 2 5 PResidence 6 □Other (Specify) this 27. Manner of Deeth Certification: 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending Investigation 1 Neturel death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Directors, completely filled in by the 3 ☐ Sulcide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. Medical 29e. Certifier (Check only one) \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Tol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATURAINA CHANG, M.D 10701 Naw Henge Creek S.W Smile 3 Front Cens Hary Jane 21532 31. Date filed (Month, Dey, Year)

State Registrar

MAR 1 0 2000

See Signature Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

				1	Certificate d	of Death	R	leg. No.	J	099	22
Phys	ioian	1. Decedent's Neme (First, Middle	e, Last)	True.			2. Date of Dea Month		Year	3. Time of	Death
Physi /Me	dical	Stanley	A.	Mí.	ller	Sr.	March	13, 200	0	12:15	a.m.
Exan	niner	4a Fecility Name (If not institution	, give street and number))		4b. City, Town, or	Location of Death	4c. County of	Death		
View 1		Memorial Hospit			irthday) If Under 1 Ye	Cumberla		Alleg			
Funera		5. Social Security Number 233 - 78 - 4680	6. Sex 7. Ag	ge (In yrs. last b 52	Yrs. Months De			Year) 1948	9. Birthp Coun	piace (Stete o	r Foreign
Directo	ər	Usuel Residence of Decedent	A	34			100 20	, 1516		110	
/land		10a. State 10b. County		10d. Inside City Limits							
Man Hah	to	WV Min	eral	ì	Ridgeley			1 🗆 Yes	X □No		
h the	5	10e. Street and Number			10f. Zip Coo	e	1	log. Citizen of Wh	en of What Country?		
death with the Maryland ime 23a or 28a-f ahow	Funeral Director	Route 3 Box 4	95			26753		USA			
des r	- Tue	11, Meritel Stetus	12. Wes Decedent Armed Forces	Ever in U,S.	13. Was Decedent II Yes, specify 0	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- Americ White,	can Indien, etc.	
o a	by Fu	1 Never Merried 2 Merr	ed 1 ☐ Yes 2任 If Yes, Give	No	1□ Yes 2□			Specify:	whi	te	
should be filled within 72 hours after death with the Marylan nd Mental Hygiene. The marked other than "natural", or itama 29s or 28s-1 show urratic avent, the Medical Exercises man be notified as	D D	3 Widowed 4 Divorced	Year or Dates:	100	a. Decedent's Usuel Oc			16b. Kind of Busi			
d within 72 hours af glene. In then "netural", or	Be Completed	(Specify only highes	t grade completed)		(Give kind of work do life. DO NOT use re	ne during most of wo	rking	100. Kind of Busi	11622111	dustry	
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and series	0	17. Father's Neme (First, Middle,					me (First, Middle,)		
ould be filed Mental Hygi arked other atic avant, it	ToB	George Stanle	y Miller			Laura E	(Brov	m)			
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1 and Health em 27		wife 20a. Method of Disposition	CL								
permit. Pages 1 ar Department of Hea mportant: if Item in Injury or other		20a. Method of Disposition Burial 2 Cremetion	3 □Removel from Stete	an-mat	of Disposition (Name of ary, cremetory or other	plece)	Dete	20c. Location - C	ity or To	own, State	
Pa mem mem:		4 □ Donetion 5 □ Other (S)	pecify)		emetery		3/15/	Short	Gap	, WV	
permit. Pag Department Important: I any Injury o	9	21. Signeture of Funeral Service	Licensee	1//-	-	of Fener		P.A.			
- PD - 4		Michalas	1.00a1	Dolly		and, MD					
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Physician /Medica	_	Immediete Cause (Finel								Orisot and L	/oau
Examine		disease or condition resulting in deeth)	. Cardia	c arres	t					13,20	
	6				consequenca of):				1		
Den Den Den Den Den Den Den Den Den Den	를		b. Perito		consequenca of):			Feb 27,200		, 2000	
exec in an	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	2								
rificate be executed ng physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Perito	nial di Due 10 (or as a	alysis consequence of):			5 year	rs		
를 모해	5	resulting in death) Last							- 1		
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Phy rthis	: To	27. Manner of Death	28a. Date of Inju		-	njury et Work?	Y	ow injury occurre		·y)	
or Attanding Physician: Taffer death. Director: After this certifical in by the funeral director, p	tlo	1.⊠Neturel 5 ☐ Pendin 2 ☐ Accident investig		ly Year)		Work? I ☐ Yes 2 ☐ No					
or Attanding I after death. Director: After I in by the fune	Hea	3 Suicide 6 Could a	ined 286. Place of In	jury - At home, f	ferm, street, lactory, off	ice	281. Location (S City or Tow	treet and Number	r or Run	al Route Num	ber,
a after a Direct of in b	Certification:	4 Homicide	building, et	tc. (Specify)			Only or You	ii, Siare)			
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29e. Certifier 1 Certifyin	g Physician: To the best Examiner: On the basis of	of my knowledg	e, deeth occurred at th	e time, date end place	e, end due to the d	ause(s) and man	ner as s	stated. o the cause/s	()
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To To	3										
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h	10	30. Name and eddress of person									
_		Dr. Shiv C. K 31. Dete filed (Month, Day, Year)		E Natio	nal Highway	; LaVale,	MD 2150)2			
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Department of Important: If any Injury or

Physician

Examiner

attending physician and for use as the burial-transit

page 2 should

this funeral

After

/Medical

Baltimore, Maryland 21215-0020

or Attending Physician: Division death. To the Hospital or Attenditional within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number

D 3 5 3 18 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ans

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 Memorial Ave., Cumberland, MD 21502 Jeffrey Davis, M. D.

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years State Registrar

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31. Date filed (Month, Day, Year) MAR 13 2000

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Amended #23b, 28a, Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene 00 09924

3/16/00					Certificat	e of Death		Reg. No.) (3367
Division	la.	1. Decedent's Neme (First, Middle	, Last)				2. Date of Do		Year	3. Tima of Death
Physic /Med		Katherine	C.	Pai	rry		MARCH			5:05 A.M.
Exami		4a Facility Neme (If not institution	, give street and number)		4b. City, Tow	vn, or Location of Deat	h 4c. County	of Death	
		Memorial Hospi		al Cente		Cumber	land	A	llega	ny
Funeral Director		5. Social Security Number 213 - 24 - 5542	6. Sex 1 M 2 F 7. A	ge (In yrs. last bi	Yrs. If Under Months	1 Year If Under 2 Days Hours	Min. 8. Date of Bi (Month, D. Jan 10	th ay, Year) , 1921	9. Birthp Coun	place (State or Foreign http) WV
1 t.		Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	m or Location				1	0d. Inside City Limits
Mary A sh	to	MD All	egany		Cumberl	and				Yes 2 No
r 28a	Directo	10e. Street and Number	egany		10f. Zip			10g. Citizen of \	What Coun	itry?
ath with the Man 23e or 28e-f sh sust be notified.		110 W. Third	Street			2150	2	USA		
Ter do	by Funeral	11. Meritel Stetus 1 Never Merried 2 Merri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' ed 1 Yes 2 H If Yes, Give Yeer or Detes:		13. Was Dece If Yes, spe 1 Yes		in? (Specify Yes or Ne. Puerto Rican, etc.)		e - Americ ck, White,	etc.
21215-0020 ad within 72 hours at or then: or then fretural, or t. the Medical Exam	pet	15. Decedent		16a	. Decedent's Usus	al Occupation		16b. Kind of B		
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OD OD O		27. Menner of Deeth 1 型Neturel 5 □ Pending	28a. Dete of Inju	ay Year)	Injury	28c. Injury at Work?		how injury occur	red	
Vision Attending r death. ector: After	cati	2 Accident investig	etion	A-	М	1 Yes 2 N				10
Division or Attending after death. Director: Atte	Certification:	4 Homicide determi	ned 286. Pleca of In	jury - At home, fa tc. <i>(Specify)</i>	arm, street, factor	y, office		Street and Numb wn, State)	er or Rura	al Route Number,
pital pital		29e. Certifier 117 Certifying	Physician: To the best	of my knowledge	doub coourad	at the time, date and	I place and due to the	cours(s) and m	2000100	tatad
Hos 24 h Fun etely	edical	(Check only 2 Medical E	xaminer: On the basis of and menner st	of examinetion ar	d/or investigation	, in my opinion, deat	h occurred at the time,	date end place,	and due to	the cause(s)
Division of Vital Returned to the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate in completely filled in by the funeral director, page	Me	29b. Signature and title of confider	7-11	-	290	c. License number		29d. Date signe	d (Month,	Dey, Year)
5		1. Then	obt.		DO	054004		MARCH	10	2000
		30. Name and address of person v	no completed cause of	death (Item 23a)		25 Kent A		ite 101	10	2000
The Man	لما	Dr Chir Vhanna	Tohnson III						21502	
Sta	ate	31. Dete filed (Manth, Day, Year) MAR 1 0 2	32. Regist	rer's Signature	1 1		Competiallo	, 1111	-4-04	
Regist		MAR I U Z	JUU Dene	No 1	1 400	who				

DHMH 16 Ray 6/95

213-24-5542

KATHERINE PARRY

MARINE Second STATE

Amended #20c, NLS, Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 3/9/00, Allegany Co. State of Maryland / Department of Health and Mental Hygiene 09925 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Year **Physician** ANNA 1 2000 VERONICA RITCHIE 1:50 PM. MARCH /Medical 4e Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER B ALTI MORE PUSEDALE | FUnder 24 Hrs. | 8. Data of Birth | Hours | Min. | NOV 13 , 1915 If Under 1 Yeer 5. Social Security Number 7. Aga (In yrs. last birthdey) 9. Birthplaca (Stata or Foreign **Funeral** 1 ☐ M 2 🛛 F 84 MARYLAND 217-10-5371 Director Usual Rasidance of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits N Yes 2 No Director MD ALLEGANY CUMBERLAND or 25n-1 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 11 NORTH LEE STREET 21502 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yas 2 ☑ No Specify: Specify: WHITE þ 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 8 Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be EDWARD C. MACE ANNIE ROWAN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other to HELEN F. KELLY / DAUGHTER 4 ELEANOR STREET, LAVALE, MD 21502 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Cumberland B 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removel from State SUNSET MEMORIAL PARK 3/8/00 LAVALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nema and Address of Facility UPCHURCH FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediate Cause (Final disaasa or condition rasulting In daath) /Medical . HEMORRHAGIC STROKE 6 HOURS Examiner Examine Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or es a consequance of). Physician/Medical Due to (or es a consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medicel examinar? Medical Certification: To Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Inpatiant 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 2 Natural 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending invastigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi r death. 1 Yas 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicida 187 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifiar

Box 68760 P.O. Records, of Vital Division

Registrar

(Check only

31. Data filed (Mo

29b. Signatura and titla of certifier

9000 FRANKLIN SQUARK DR BALTO, 117 21237 ROESE NO 32. Registrar's Signatur

30. Nama and addrass of person who completed ceusa of daath (Itam 23a) (Type, Print)

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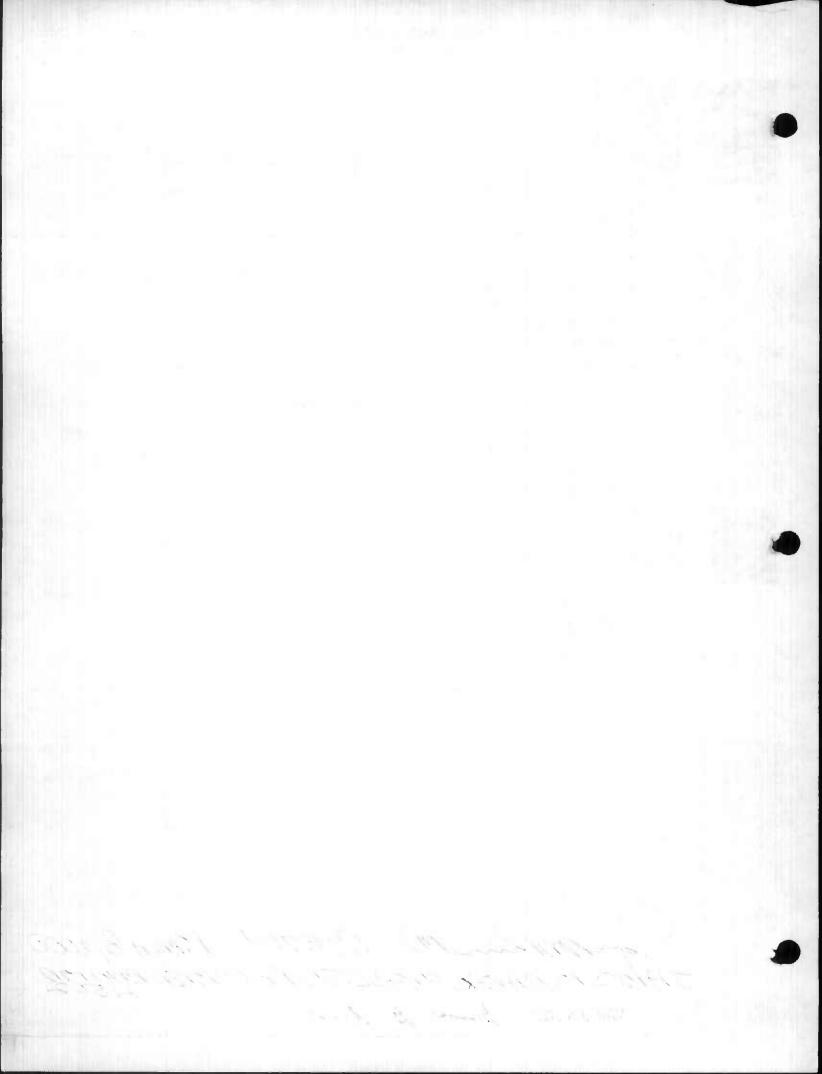
29c. Licensa number

29d. Dete signed (Month, Day, Year)

RD# 187337 NARCH 4, 2000

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						Ce	ertificat	te oi	Death		R	eg. No.		
Physicia: /Medica		Decedent's Neme (First, Mic Freda	ldle, La	M.		Rob	inett	e			2. Data of Dee Man	5, Dey 200	Q _{ear}	3. Time of Death 07:25am
Examine		4e. Facility Neme (If not Institute Memorial Ho			umber)				Cumb	erl		4c. County		legany
Funeral Director		5. Sociel Security Number 217-10-5495	6. 5	Sex I□M ¾ □F	7. Age (In	yrs. last birthday 81 Yrs.	Months	Day:		24 Hrs. Min.	8. Dete of Birth James 2 Pay	Year 919	9. Birth Cou	piece (State or Foreig
pue *	1	Usuel Rasidance of Decedent 10a. Stete 10b. Cour	hv		100	. City, Town or L	ocation							and incide O'm I be in
death with the Maryland	ector	MD A	•	egany			ımber	_	nd					10d. inside City Llmit
free must be n	Funeral Director	10e. Street end Number 106 Columbi	a	Street			10f. Zip	o Code	21	502	10g. Citizen of When			intry?
urs efter	þ	11. Merital Status 1 □ Never Merried 2 □ M 3 ☑ Widowed 4 □ Divorce		12. Wes Dec Armed F 1 Yes If Yes, G Yaer or I	orces?√ 2 □ No iva	in U,S. 13.	Was Dece If Yes, spe 1☐ Yes				ecify Yas or No- Rican, etc.)	Bled	e - Amer ck, White www.wh:	
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permit. Pages 1 end 2 Department of Health of Important: If Item 27 is any Injury or other tra OUCS.		daughter 20e. Method of Disposition 15 Burial 2 Cremetion			Stete	b. Plece of Disp cematary, cre	metory or o	other pi	1 - 1	1-		20c. Location -		
Departme Importan any injur	Ì	4 Donation 5 Other 21. Signature of Funeral Service				Sunset	2Sera 1	pe	est of Fequ	une:	ral Hon	ne P.A	•	na, MD
	\dashv	23a. Part1. Enter the disease, shock, or heart failure. Li	or com	plications that	called the c	leeth Do not er					ryland	2150	Z 	Approximata
Physician /Medical Examiner		immediate Cause (Final disease or condition resulting in deeth)	n oley		irator	y Failu	re							intervel Between Onsat and Deeth
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signed by the document of the detach	Pert II. Other eignificant conditions contributing to death but not resulting in the undarlying causa given in Part I. Coronary Artery Disease								1 XYee 2 No 3			obably 4 Unknow		
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certificate has rector, page 2	5										1 🗆 Ye	s 2 No	1	☐ Yes 2☐ No
ysician: s certific director,	Re	25. Wes case referred to medic axaminer?	ai						26. Plece	of Deat	th (Check only on	е)	-	
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Attending P or death. Setor: After the funeral by the funeral or or or or or or or or or or or or or	Certification:	27. Menner of Deeth 1 Naturel 5 Pence Investigation 2 Accident Investigation 3 Suicide 6 Coul	tigation	1	nth, Dey Yea		M		Yes 2	No	28d. Dascribe ho			
vital or Attenders after death		4 ☐ Homicide data	mined	build		At home, ferm, s ecify)					City or Town	n, Stata)		rel Route Number,
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20		29b. Signature and title of certif	2	Mh	~	M	1	2	87	69	1 1	Anut	1 E) 2000
0	(30 Name and address of person	7,	RAV	ER	908	Print)	70	MI	n,	wm	sen	gni	5020
State Registrar	=	31. Dete filed (Month, Day, Yea MAR 0	_	000	Registrer's Si	gnature	1	lon.	Nal					



Physician /Medicai Examiner The law requires that the death certificate be executed

permit. Pages 1 and 2 sh Department of Health and Important; If then 27 is m any injury or other traum phos.

Physician

/Medical

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r 28a-1 show a notified at

ed other than "natural", or items 23s or event, the Medical Examiner must be r

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The Maryland

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Baltimore,

Box 68760.

Records, P.O.

Division of Vital

Examiner Physician/Medical by Completed Be 2

Certification:

physician and the burial-transit for use as ed by the a signed by the should should certificate has b or Attending Physician: director, this After this death. after death Director: / To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Ceusa (Diseasa or injury thet initiated avents rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. complation of cause of daath? 1 Yas 2 No 1 Yas 2 No 25. Wes casa rafarred to medical axaminar? 26. Placa of Daath (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, deta end pleca, and dua to tha causa(s) and manner es steted.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the causa(s) and manner stated. 29a. Certifiar

29c. Licensa number

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29d. Data signad (Month, Day, Year)

March 10, 2000

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Medical

State Registrar

(Check only one)

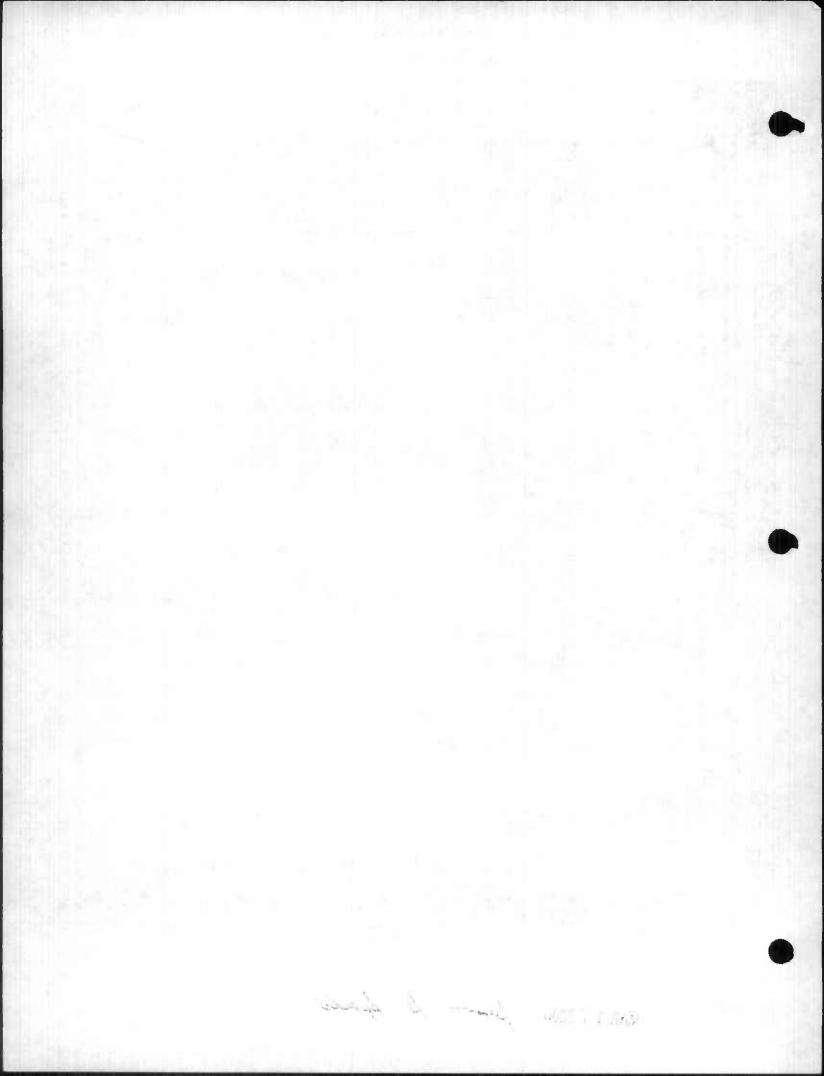
29b. Signatura and titla of certifian

37 Agrant Avenue, Cumberland, MD 21502 Suni 1 K. Supta, M.D.
MAR 1 3 2000 souls

30. Nama and addrass of parson who completed cause of death (Item 23a) (Type, Print)

words of many the sink

	Certificate of	of Death Reg. No.
Physician /Medical	EDWARD ALVIN RICHARDS	2. Date of Death Month Day Year March 14, 2000 1756
Examiner	4a Fecility Name (If not institution, give street end number) SACRED HEART HOSPITAL	4b. City, Town, or Location of Death CUMBERLAND 4c. County of Death ALLEGANY
uneral Pirector	5. Social Security Number 2 17 10 5941 Usual Residence of Decedent 6. Sex 12 M 2 F 85 7. Age (In yrs. last birthdey) Months Day Months Day	
Now I	10a. State 10b. County 10c. City, Town or Location	10d. Inside City
or 28a-1 show be nothing at Director	MARYLAND ALLEGANY FROSTBURG	1 ☐ Yes
° 5 0	19308 UPPER CONSOL ROAD, NW 2153	
natural, or Name 234 rates Exercises must	3 ☐ Widowed 4 ☑ Divorced Yeer or Detes:	of Hispenic Origin? (Specify Yes or No- luban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC	ne during most of working lired)
f Heelth and Mental Hyglen from 27 is marked other the other trsumatic event, the other trsumatic event, the To Be Com		18. Mother's Name (First, Middle, Maiden Surneme)
	JOHN RICHARDS	MARGARET PLUMMER
amna .		eet end Number or Rural Route Number, City or Town, Stete, Zip Code)
important: If item 27 any injury or other it	20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other)	IAL PARK 3/17/00 FROSTBURG, MD
ician dical niner Examiner	Immediate Cause (Finel disease or complications that caused the death. Do not enter the mode of control of the cause of condition resulting in death) Sequentially list conditions, if any leading to immediate cause.	NERAL HOME, P.A. N ST., FROSTBURG, MD 21532 dying, such as cardiac or respiretory errest, PATORY FIAILURE 10 DA HYPERTENSION 5 YEA PACTIVE PALMONARY
should be detached for use as the but leted by Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse ATRIAL FIBRILLATION	N 1 Yaa 2 No 3 Probably 4 U
ON O.	CONGESTIVE HEART TO RENAL FAILURE	24a. Was an autopsy performed? 24b. Were autopsy fit available prior to completion of call of death?
s certificata has director, page 2 To Be Comp	25. Wes cese reterred to medical	28. Place of Deeth (Check only one)
00	12 Inpatient 2 ENVOutpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify) njury at Work? 1 Yes 2 No
To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	3 Suicide 4 Homicide 6 Could not ba determined 28e. Plece of Injury - At home, farm, street, fectory, offi building, etc. (Specify)	ce 28f. Location (Street and Number or Rural Route Number of Town, Stete)
plately fill edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the desired form of the basis of examination and/or investigation, in mand manner state.	e time, date and place, end due to the cause(s) and manner as stated. ny opinion, death occurred at the time, date and place, and due to tha cause(s)
T S		ense number 29d. Dete signed (Month, Day, Year) March 15, 2000
Nes	30 Name and address of berson who confered ceuse of death (Item 23a) (Type, Print) Chang Oh M. B. 48 Tarn Terrace, F.	rostburg MD 21532
State	31. Date filed (Month, Dey, Yell) 32. Registrer's Signature	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month Day **Physician** 8 2000 5:57 AM MARCH Clarence N.M.N. Stevens /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street end number) 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland ar If Undar 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Min. 1)X M 2 F Months Days Yrs. Director 220-07-6708 23-Jul-06 Maryland Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits Hem 27 is marked other than "natural", or Nems 23s or 28s-4 show other traumstic event, the Medical Examinar must be notified at 1 NYes 2 No Director Maryland Allegany Frostburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 Jenkins Street Funeral death U.S.A. 14. Race - American Indian, 12. Was Decedant Ever in U,S. Armed Forces? 1 1 2 1 Yas 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after call Hygiena. 1 □ Navar Married 2 □ Married Baltlmore, Maryland 21215-0020 1 Yas 2 No Specify. Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlega (1-4or 5+) music teacher self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental th Important: if them 27 Is marked oth any Injury or other traumatic even DRB. Be 2 **Eugene Stevens** Agnes Stevens 19b. Mailing Address (Street end Number or Rural Routa Numbar, City or Town, Stete, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) 20b. Place of Disposition (Neme of cametary, cremetory or other place) Jay Stevens Maryland 21532= 20c. Location - City or Town, State Nephew 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Othar (Specify) Frostburg Memorial Park Frostburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Batween Onset and Death Physician tmmediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner sician and bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last certificate be execu been signed by the attending physician should be detached for use as the buna 0454/0pah, Box 68760 Physician/Medical Due to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed' page 2 has 1□ Yes →No certificata 1 ☐ Yes 2 ☐ No offer death.

Director: After this certifica funeral director, 25. Was case referred to madical Be 26. Place of Death (Check only ona) axaminar? Othar: 1 Yes 2 No 2 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 1. Natural 5 Pending 2 No 1 Yes investigation 2 Accident 6 Could not be detarmined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stele) 3 Suicida 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida To the Hospital of within 24 hours of To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 29a. Cartitian edical 2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signeture and Title of certifier 29d. Date signed (Month, Dey, Year) w horry ath (Item 23a) (Type, Print) and address of person d cause of Thomas 31. Dete filed (Month, Dey, Year) Registrar's Signature State Registrar MAR 0 8 2000 **DHMH 16 Rev 6/95**

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\$CE 5	Maryland	as the other food. Frostburg	er er	veriger	Joy Stevens
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Durst Functal Horne, 57 Host Ave., Froshing, MI 21572

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State of Maryland / Department of Health and Mental Hygiene \(\Omega\) \(\Omega\) \(\Omega\) \(\Omega\)

					Certific	ate o	f Death		Reg. No.	, 0	5500	
	Physician /Medical	Decedent's Name (First, Middla STELLA ST	Last) HEETS					2. Dete of I		OYear	3. Time of Death 5:30 PM	
	Examiner	4e Facility Neme (If not institution, 13004 ELLERSLII					4b. City, Town, o	AND		y of Death LEGAN	ΙΥ	
	Funeral Director	219-10-1844	5. Sax 7. A	x 7. Aga (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours					8. Dete of Birth (Month, Day, Year) OCT / 1923			
	Maryland f show led.at	Usual Residence of Decedent 10a. Stata 10b. County MARYLAND ALLE	ANV	10c. City, Town or Location CUMBERLAND				71		1	10d. Inside City Limits 1√2 Yes 2 □ No	
	a or 28e-f a at De notified of Director	10a. Street and Number 815 MEMORIAL A		Com		Zip Code			10g. Citizen of	What Cour	ntry?	
020	irs after death in it, or thems 23 Cambber mast	11. Marital Status 1 Never Merried 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden	? No		. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert				ace - American Indian, leck, White, etc.		
21215-0020	ed within 72 hor yglene. wer than "mahura it, the Medical B	15. Decedent' (Specify only highest Elementery/Secondary (0-12)			16a. Decedent's (Give kind of life. DO NO	f work do	ne during most of w	orking	16b. Kind of B	usiness/in	dustry	
	Mental Hygene rhad other tha rife event, tha To Be Com	17. Father's Neme (First, Middle, L		(34)	HOUSE F	EEPE			ne (First, Middle, Meiden Sumai		SE KEEPER	
, Maryland	and 2 should assith and Month and Mo	19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, CAROL LOGSDON DAUGHTER P.O.BOX# 61 CORRIGANVILLE MARYLAND 2152									4	
Baltimore	Pages 1 ment of H ant: If lear ury or oth	20a. Method of Disposition 1 Duriai 2 Cremetion 4 Donetion 5 Other (Sp.		Ce	ece of Disposition metery, crematory SET CEME	or other p		2000	20c. Location			
Balt	Departi Depart Import any in	21. Signature of Funeral Service L	Meint	1	MERR	TT-A	dress of Facility ADAMS FUNI THE STREET			RYT.ANI)	
	Physician	23a. Pert1. Enter the diseese, or of shock, or heart failura. List of	nly one ceuse on eech					Approximata Interval Between Onset and Deeth				
	/Medical Examiner	Immediate Cause (Final disease or condition rasulting in death)	Disen	seminated Adenocarcin Due to (or as a consequence of): eleus Carcinoma of flu				nouna		1	4.mo	
6	executed ist-transit	Sequentially list conditions, if any, leeding to immediate	b. Holem	Due to (or	as a consequence	O):	of the	lung		1	7 mo	
68760,	g physicia as the bur fedical	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or Injury thet initieted events resulting in deeth) Lest	c	Due to (or	es e consequence	of):				1		
.O. Box	The law requires that the death certained has been signed by the attending page 2 should be detached for usa Completed by Physician/N	Part II. Other eignificant condition	d	but not resul	ting In the underly	ng cause	given in Part I.	23b. Di	d tobacco use co	ontribute t	o the cause of death'	
0	requires that the seen signed by nould be detected by Physical Phy	Possible Chr	ronic M.	rjelose	4005	hevi	Komis	-1	Yee No	24b. W	bebly 4 Unknow	
Records,	The law require ate has been single bage 2 should I completed	by for leusi	m i c						rformed?	of	ompletion of cause death?	
Vital	ysician: The law is certificate has t director, page 2 s To Be Compli	25. Was case referred to medical examiner?	Hospitel:	F			Other	eeth (Check on)	y one)		☐ Yes 2☐ No	
of	2 E -	27. Manner of Death 1 Neturel 5 Pending	28a. Date of In		R/Outpatient 3C 28b. Time of Injury	DOA 28c. tr		_	e how injury occu		(y)	
ivision	or Attending Phier death. rector: After thin by the funeral tiffication:	2 Accident investige 3 Suicide 6 Could no 4 Homicide determin	tion 28e. Piece of in		M ne, ferm, street, fe	1	☐ Yes 2 ☐ No	28f. Location City or 7	(Street and Num Town, State)	ber or Run	al Route Number,	

MUS

29e. Cartifier (Check only one)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 925 BISHOP WALSH DRIVE DR V.R. FELIPA

CUMBERLAND MARYLAND 21502

29d. Date signed (Month, Day, Year)

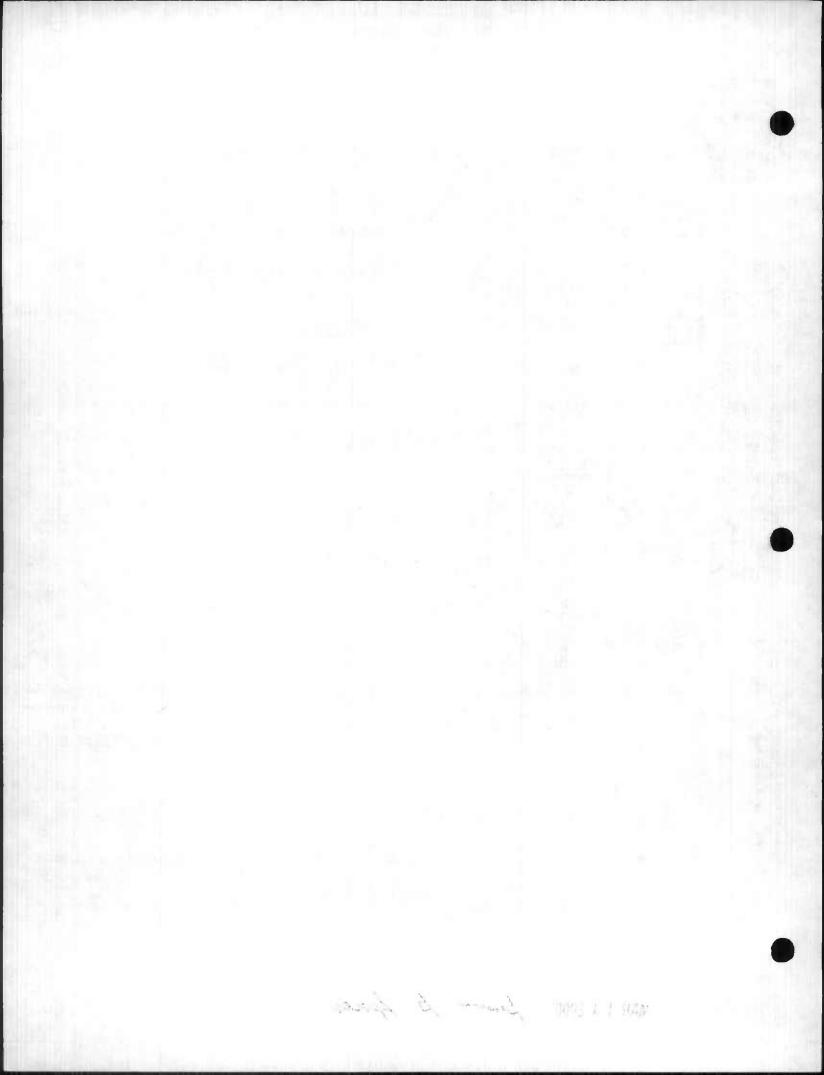
MARCH 13, 2000

State Registrar

1 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner-stated. 29c. License number

D 13601



Piease Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last)

ANNABELLE MADSEN TOTUSHEK

Physician

Reg. No.

29d. Data signed (Month, Day, Year)

Maiden Chorce lane, Catonsville, MD, 21228

March 24, 2000

3. Time of Death

2. Date of Death

Registrar DHMH 16 Ray 6/95

State

29b. Signeture and title of certifier

Men

3) Data filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

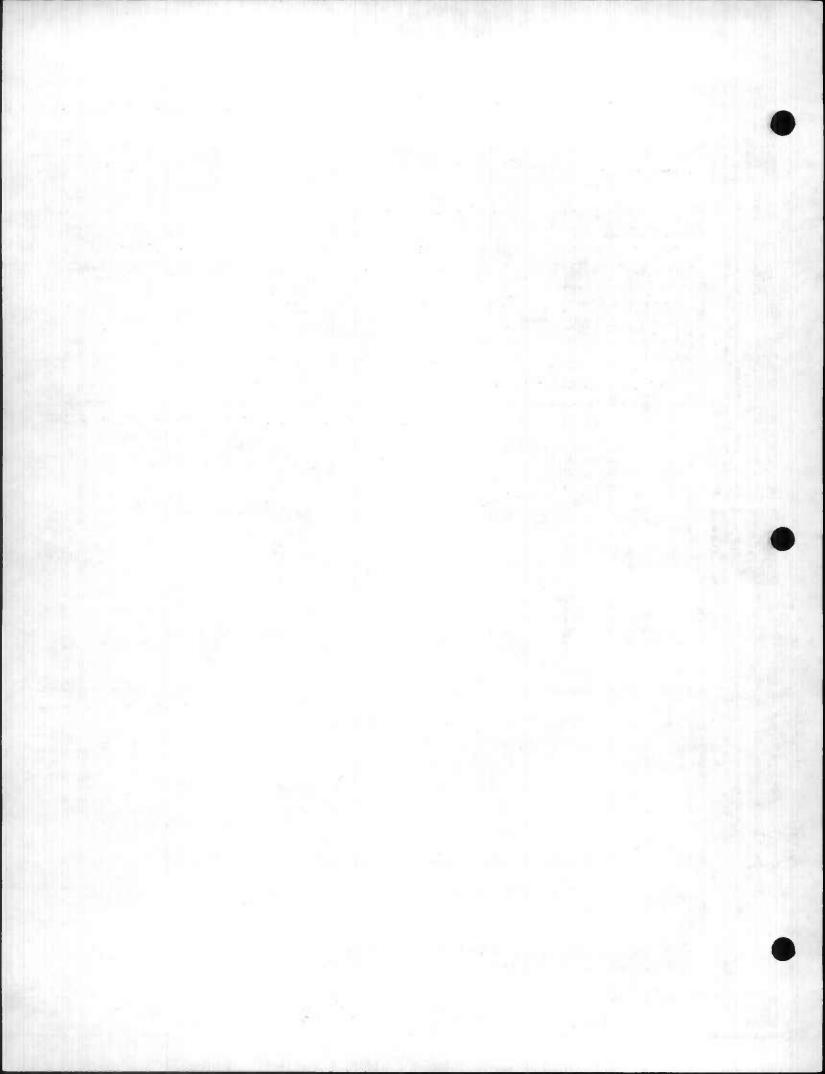
32. Registrar's Signeture

Massara

5alazax

MAR 2 7 2000

29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended #23a(a), NLS, 3/9/00, Allegany County State of Maryland / Department of Health and Mental Hygiene 09932 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Tima of Death Physician Charles Thrasher March 3, 2000 /Medical 5:15 PM 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Memorial Hospital & Medical Center Cumber land Allegany If Under 1 Year 8. Dete of Birth Sep 2, 1931 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 15M 20F 213-24-6634 68 Yrs. Director Usuel Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow man be notified at 1 Yes 2 No Director MD Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 Braddock Road 21502 USA Funerai 12. Was Decedent Ever in U.S.

Xarmed Forces?

Yarmed Forces?

Yes 2 No
If Yes, Give 1952-60 Hema: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene. Int: If Itam 27 Ia marked other than "natural", or Ita 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ YNo Specify: Specify: white by 3 Widowed 4 Deivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 10^{College (1-4or 5+)} Elementary/Secondery (0-12) Ret. Accounting Depts Tire Company Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Paul L. Thrasher Frances K (Dycke) 19a, Informent's Name/Relationship (Type, Print)
Tonia L. Kimble 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code)
ROUTE 2 BOX 207B; Keyser WV 26726 or other tra daughter
10e. Method of Disposition
1 Buriel 2 Cremetion 3 Removal from State 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, Stete Department of Important: If any injury or once. Sunset Memorial Park! 4 ☐ Donetion 5 ☐ Other (Specify) 3/06/ Cumberland, MD 21. Signature of Funeral Service Licenses 23 temped if Funeral Home P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** immediate Causa (Final disease or condition resulting in deeth) /Medical Renal-Failure Acute Tubular Necrosis 2 weeks Examiner Due to (or as a consequence of): Examiner 2 weeks Septic Shock Sequentiatly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest the burial-tra-Due to (or es a consequence of): certificate be execu Box 68760. physician Physician/Medicai 213-24-6634 Due to (or as a consequence of): 080 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 2 1 Yaa 20 No 3 Probably 4 Unknown 0 Diabetes Mellitus Records, by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed The law certificate has page 2 1 Yes 2 No 1 Yas 2 No Division of Vital Charles Thrasher Be 25. Was case referred to medicat axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No After this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 1 Neturat 5 Pending investigation 1 Yes 2 No death. 2 Accident the after death 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 2 4 Homicide b 2 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only

To the Hospital within 24 hours a To the Funeral C

completely

com mo 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) nes

William Lamm,

31. Date filed (Month, Dey, Year) State MAR 0 9 2000 Registrar

one)

29b. Signeture end title of cartifier

M.D., 32. Registrer's Signet

Virginia Avenue, Cumberland, MD

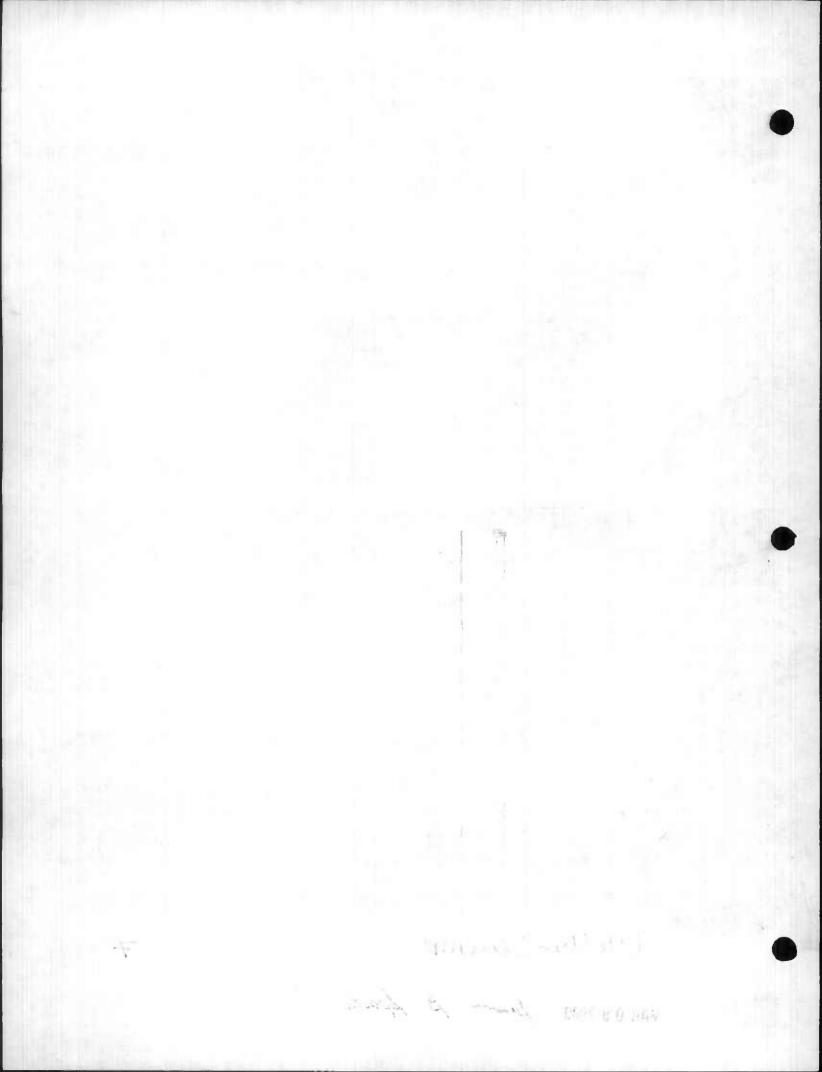
29c. License number

D 25406

29d. Date signed (Month, Day, Year)

March

2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 10 2000 WAYNE LEONARD 3:30 AM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 1429 MAGNOLIA COURT CUMBERLAND ALLEGANY If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Yes 65 Director 215-26-9956 JUNE 1 1934 MARYLAND Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiane. other than "natural", or flems 23a or 28a-f abow yeart, the Medical Examiner must be notified at 1 X Yes 2 No MARYLAND ALLEGANY CUMBERLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1429 MAGNOLIA COURT 21502 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. Affice Potestal

No
If Yes, Give
Year or Dates: 1952-1954 1 ☐ Never Married 2 ☑ Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 3-M COMPANY 12+ SALES PERSON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fit.
Department of Health and Mental th,
Important: if Nam 27 Is marked oth
any Injury or other traumatic avantables. 8 MABEL MARGARET KELLY LEONARD WAYNE THOMAS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE 1429 MAGNOLIA COURT CUMBERLAND MARYLAND 21502 YVONNE K. THOMAS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 □Other (Specify) ST MARYS CEMETERY MARCH 13 2000 CUMBERLAND MARYLAND 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND O 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Transitional Cell Carcinona Examiner reinaura of the Vrinary Bladde 13 year Examiner physician and the buriai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760 that the desth certificate be edical Due to (or as a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. á 1 Yes 2 No 3 Probably 4 Unknown signed to det Records, by should 24b. Were autopsy findings eveilable prior to 24a. Was en autopsy performed? Completed completion of cause of death? page 2 certificata 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To 1 Yes 2 No this funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier L Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and manner stated. (Check only 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier D 13601 MARCH 13, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR V.R. FELIPA 925 BISHOP WALSH DRIVE CUMBERLAND MARYLAND 31. Date filed (Month, Day, Year)

State Registrar

MAR 13 2000 **DHMH 16 Rev 6/95**

32. Registrar's Signatus

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Daia of Daath 3. Tima of Deeth **Physician** Marth 14, Day 000 Yaar 03:45pm Elizabeth Yoder Dorothy /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Nursing Center Cumberland H Undar 1 Yaar H Undar 24 Hrs. 8. Data of Birth Months Days Hours Min. Jan 1907 224, Year 914 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthpleca (Stata or Foraign **Funeral** Months 1 MX F 86 218-34-4468 Yrs. Director Usuai Rasidanca of Dacadant with the Manyland permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Heelih and Mental Hygiane.
Important: If tem 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or other traumatic event, the Medical Exprince must be notified at any Injury or other traumatic event, the Medical Exprince must be notified at 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits DIrector 10e 1X Yas 2 No Allegany Cumberland 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 13813 Maple Tree Lane, SW 21502 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas* 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacadant of Hispanic Orlgin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Biack, White, etc. 1 Navar Married 2 Married Maryland 21215-0020 1 ☐ Yas 🏋 ☐ No Specify: Speciwhite py ₩ Widowed 4 Divorced Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Surname) Benjamin Cleveland Moreland (Culp) Anna P 19e. Informant's Name/Balationship (Type, Print)
Pat Yoder/Don Yoder 19b. Mailing Address (Streat and Number or Rural Boyte Number, City or Town, Stele, Zip Coda)
BOX 43; Pinto, MD 21556 daughter-in-law/son Baltimore, 20b. Place of Disposition (Nama of cametary, cramatory or other place) 20c. Location - City or Town, Stata X Buriai 2 Cramation 3 Ramoval from State 4 □ Donation 5 □ Othar (Spacify) Pinto Mennonite Cemete3/18/ Pinto, MD 21. Signature of Funaral Service License Scarpe Wes of Februaral Home P.A. bilications that ceusad the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, one cause on each line. 21502 Part I. Entar the disaasa, or com shock, or haart failura. List only Approximata Intarvai Batw Onsat and Death Physician /Medicai Immediala Causa (Final disaasa or condition resulting in daath) Examiner Dua to or as a consequence of end il-trensit 1200a Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in deeth) Lasi Due to (or as a consaguence of): burialphysician s the buria 8 Physician/Medical Dua to (or as a consaquanca of): for use es t signed by the ette Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to complation of cause of death? 24e. Wes an autopsy performad? Completed peen has 1□Yes 2 No 1 Yas 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific 25. Was case referred to medical axaminer? Be 28. Pieca of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 10 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Mannar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidani the 6 ☐ Could not be datarminad 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 3 Suicida 28a. Place of Injury - Ai homa, farm, siraal, factory, offica building, atc. (Specify) in by 4 ☐ Homicide 29a. Cartifiar 1🗹 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha ceusa(s) and mennar as stated. Medical 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and title of cerutier 29c. Licansa number 29d. Data signed (Month, Day, Year)

he. State Registrar

Shiv Khanna, M.D.; 1221-E National Highway; LaVale, MD 21502

30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print)

32 Aggistrar's Signetura

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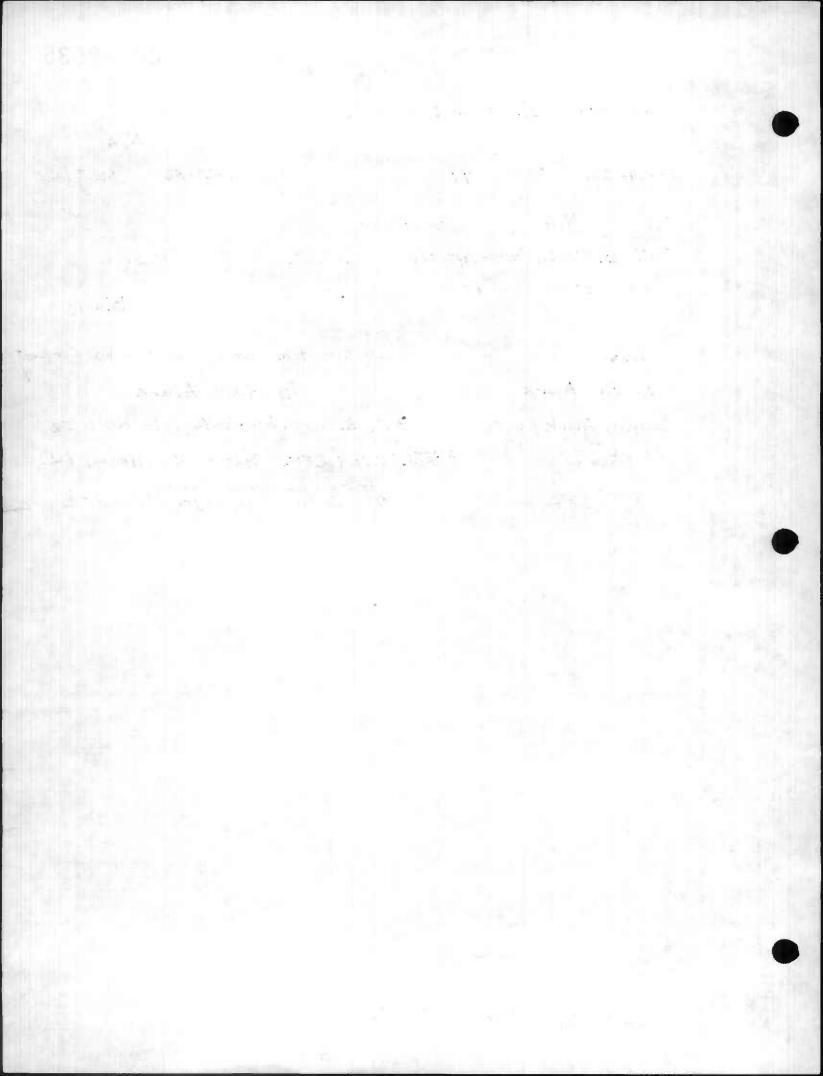
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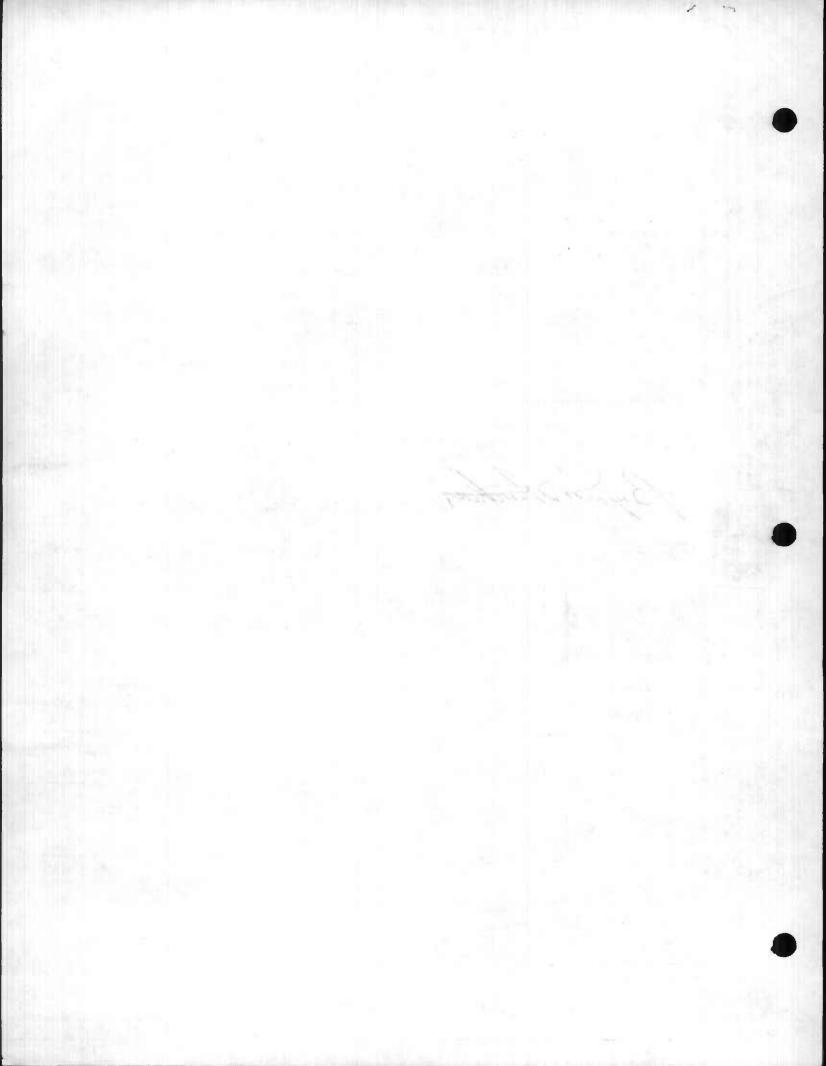
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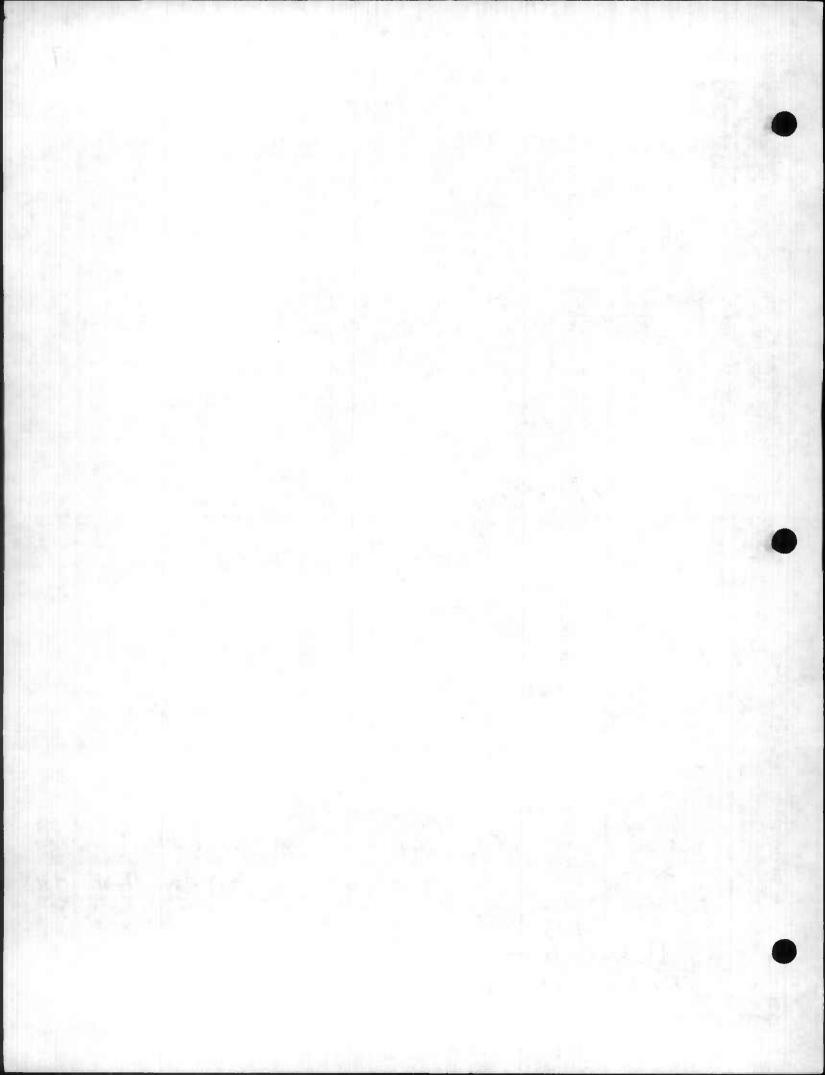
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ician								- 11	eg. No.			
	Decedent's Neme (First, Middle,	Last)						ete of Deel		Year	3. Time of Death	
dical	NANCY	ANDEF	RSON				Ma	rch 2			12:41 A	
niner	4a Facility Name (If not institution,	giva street and number)			4	4b. City, Tow	m, or Locatio	n of Death	4c. County o	of Deeth		
	Washington Adventist Hospital Takoma Park Montgomer										V	
al	5. Social Security Number 6		e (In yrs. last bin	thday) If Und	er 1 Year Days	If Under 24	4 Hrs. 8. C	ate of Birth Month, Dey			ace (Stete or Fore	
or	220-50-8557 Usual Residence of Decedent	1□ M 20XF	64	Yrs.	Days	Hours			1936		ngland	
	10a. State 10b. County		10c. City, Town or Location					10d. fnsid			d. Inside City Lim	
ō	Maryland Prince	Coorco	Laurel					1 💢 Yas			1 🔀 Yas 2 🗆 I	
Directo	10e. Street and Number	George	Laurer		ip Code			1	Oa. Citizen of W	hat Count	rv?	
ā	1030 Ward Street				20707			10g. Citizen of What Country?			•	
8		12. Wes Decedent E	Ever in 11 C			lianania Origi	ing (Canaih)		Jnited K			
by Funeral	11. Merital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yas 2 N If Yas, Giva		 13. Wes Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yas 2 ☼ No Specify: 			Puerto Ricar	n, atc.)		, Whita, e	- American Indien, Whita, etc.	
			Year or Datas:							Whit		
Completed	15. Decedent's (Specify only highest		tion 16a. Dece completed) (Give			ation during most (d)	of working		16b. Kind of Bus	siness/indi	ustry	
E D	Elementary/Secondary (0-12)	Cotlege (1-4or 5	or 5+)			7)						
8	12		H	Housewife					Own Ho			
e	17. Father's Name (First, Middle, La	ist)				18. Mother	's Name (Fin	st, Middle, I	Maidan Surname)			
2	Unknown	Joseph				Unk	cnown					
	19a. Informant's Name/Raletionship	p (Type, Print)	19b	. Mailing Addres	ss (Street	and Number	or Rural Ro	ute Number	City or Town, S	Stete, Zip (Code)	
	Peter A. Anderson	n / Uuchand	10)20 II	1 0+	T	1 W-	1	1 20707			
	20a. Method of Disposition	1 / Husband	20b. Place of	30 Ward	ame of	Laure	De De	ryland	20c. Location - 0	City or Tov	vn, State	
	1 Burial 2 □ Cremation 3		cemeter	ry, crematory or	other piec	08)						
	4 Donation 5 Other (Spe 21. Signature of uneral Service Life	-	Md. Ve	eterans'	Cem	etery	03/	28/00	Crowns	svill	e, Maryl	
Tedical Examiner											YEARS	
0 6):						(2/11/	
sician	Part II. Other significant conditions	d	it not resulting in	n the underlying		ren in Pert f.				tribute to	the cause of dea	
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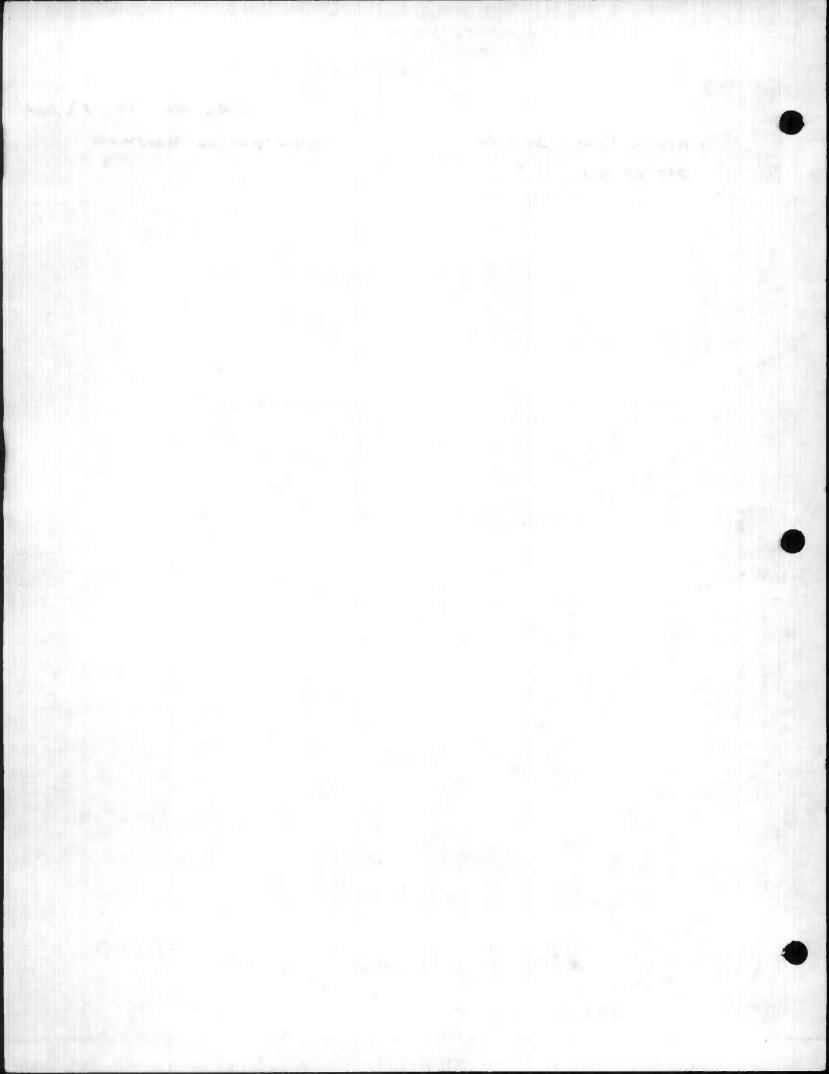


State of Maryland / Department of Health and Mental Hygien 0 0 9 9 3 7

			Certificate of	Death	Reg	g. No.	
	Decedent's Name (First, Middle, Last)	10 100	28111112	-	2. Date of Death		3. Time of Death
Physician	ERIKA DENISE	JACKSON	ADAMS		Month March 2	23, 2000 Year	4:30 A.M
/Medical Examiner	4a Facility Name (If not institution, give street and no			4b. City, Town, or Li		4c. County of Death	
Examine	2618 Asquith Street			Baltimo	ce	N/A	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday) If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9 Rinth	place (State or Foreig
Funeral Director	213-86-8137 1DM 254R	29	Yrs. Months Days	Hours Min.	(Month, Day, 1	(ear) Cou	intry) YLAND
Director	Usual Residence of Decedent	2.5			PIAI /	1970 MAK	IDAND
o bu	10a. State 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limit
the Marylan 28a-f show notified at ector	MARYLAND N/A		BALTIMORE CI	ΤTV			1∭ Yes 2□N
	10a. Street and Number		10f. Zip Code		10	g. Citizen of Whet Cou	into/?
5 8 0	2618 N. AISQUITH ST	<u> जन्म</u>	212	010		U.S.A.	
iner must		cedent Evar in U.S.			ooib. Voo or No	14. Race - Ameri	ican Indian
1 8 5	Armed F	orces?	13. Was Decedent of If Yes, specify Cul	ban, Mexican, Puerto	Rican, atc.)	Black, White	
dical Examples	M Yes, G		1 ☐ Yes 2 ☒ 💢	Specify:		Specify:	
d b						BLA	
ygiene. Ner than "natur It, the Medical. Completed	15. Decedent's Education (Specify only highest grada completed,	168	 Decedent's Usual Occu (Give kind of work done life. DO NOT use retin 	pation during most of work	ing	6b. Kind of Business/I	ndustry
S S S		(1-4or 5+)				HOMEL COMP	OD#
other three the Co	12th grade	De	OMESTIC HOTE			HOTEL COMF	ORT
	17. Father's Name (First, Middle, Last)			18. Mothers Nam	e (First, Middle, Mi	eiden Sumeme)	
To die	JOSEPH JACKSON			DOROTHY	D. TAYL	OR	
to man	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Address (Stree	of and Number or Run	ral Route Number,	City or Town, State, Zi	ip Code)
Health Item 27 other tr	Mary Smalls/Grandmother		2618 N. Aisc	quith Stre	et, Balt	imore, Mar	yland 2121
T and a	20a. Method of Disposition	comate	of Disposition (Name of ary, crematory or other plants	aca)	Data 2	Oc. Location - City or T	own, State
Ty or	1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)		ION CEMETER	y 13	-31-00 B	ALTIMORE,	MARYLAND
Departments any injudice.	21. Signature of Function Service Upingset	ess of Facility					
Den Aug	1 Jugar Son					UNERAL HOM	E PA
	23a. Part1. Enter the Complications that	elle	1206 W NO				Annovimoto
	shock, all ailure. List only one cause on	each line.	not enter the mode of dy	ing, soch as cardiac	or raspiratory arres	1	Approximate Interval Batween Onset and Deeth
Physician		1	. (1.	0 1 1	1 0-		
/Medical Examiner	Immediate Cause (Final disease or condition	Cuttor	is Non	rols to 1	beck		
	resulting in death)	Due to (or as a	consequence ot):				
, <u>r</u> <u>c</u>							
enfincate be executed ling physician and eas the bunal-transit	Sequentially list conditions,	Due to (or as a	consequence of):			1	
ian a	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying					1	
hysic the b	Ceuse (Disease or Injury that initiated events resulting In death) Last	Due to (or as a	consequence of):			1	
Mec							
attendii for use clar/	d						
igned by the atte be deteched for by Physicia	Part II. Other eignificant conditions contributing to c	death but not resulting	In the underlying cause of	iven in Part I.	23b. Did tob	esco use contribute	to the cause of death
thy sch					1□ Ye	No 3 Pr	obably 4 Unknow
y det						X	,
injarcian: The law requires that the death of his certificate has been signed by the attend if director, page 2 should be detached for us To Be Completed by Physician/					24a. Was an		Vera autopsy tindings
been s ahould					perform	0	vailable prior to
has je 2					^/		if death?
					Yes	s 2 No 1	Yes 2 No
director, page	25. Was case referred to medical axaminer?			40.00	th (Check only one	2	
r this certific ral director,		Inpatient 2 ER/O	utpatient 3 DOA	ther: 4 Nursing He	ome 5X Resider	nce 6 Other (Spec	eify)
	27. Menner of Death 1 Netural 5 Pending	of Injury nth, Day Year) 28b.	Time of 28c. Injury	ury at ork?	28d. Describe hov	w Injury occurred	
	2 Accident investigation	3/00 0		Yes 2 No	subje.	+ cus	
F 20 =	3 ☐ Suicide 6 ☐ Could not be determined	e of Injury - At home, I ling, etc. (Specify)	arm street fectory, office		28f. Location (Str. City or Town	eet and Number or Ru	ral Route Number,
d in by	SA TOTAL COMMENT	A-	THOME		2618 A	cquit28	I HAY
To the Hospital within 24 hours unithin 24 hours Completely filled	29a. Certifer 1 Certifying Physician: To the	e best of my knowledg	e, death occurred at the	time, date and place,	and due to the car	use(6) end menner as	stated.
within 24 hours after the Funeral Direction of	2∑ Medical Examiner: On that and man	pasis of examination a nner stated.	nd/or investigation, In my	opinion, death occur	red at the time, da	te and place, and due	to the cause(s)
Me of the	29b. Signature and title of certifier		29c. Licer	nse number	29	d. Date signed (Month	n, Day, Year)
- s - ō	Mar Listani			OCME	3.4	lamah 22 2	000
	Variations			O.C.M.E.	[M	larch 23, 2	000
0	30. Name and address of person who completed cau	ise of death (Item 23a)		Character .	2-14-2	34- 3 3	21201
7	J-LACON WITH	V	111 Penn	Street, E	sarrimore	, Maryland	21201
State		Registrer's Signature	19 h	cokal .			
Registrar	MAR 2 8 2000	June	La below				

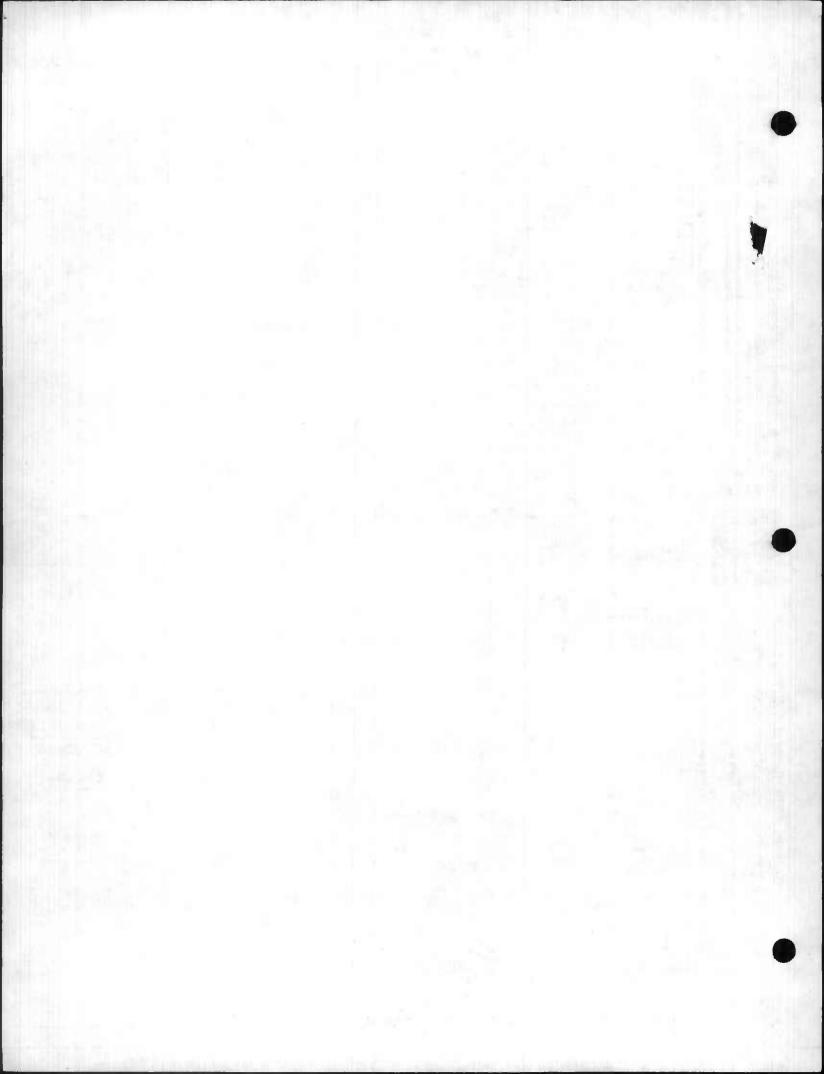


	an	1. Decedant's Nama (First, Middle,						2. Data of D Month	Reg. No. eath Day	Year	3. Time of Dea
/Medic		Lillian						MARCH	26	00	121
Examir	er	4a. Facility Nama (If not institution,					b. City, Town, or I				
		MANOR Care 5. Social Sacurity Number			and the state of	f Undar 1 Yaar	TOWSON If Undar 24 Hrs.		The same of the sa	TIMO	
Funerai Director		214-05-3615 Usual Rasidanca of Dacadant	1 M 2 F	Aga (In yrs. last l		Ionths Days	Hours Min.	8. Data of B (Month, D 8/26/			placa (State or Fo htry) LAND
M H		10a. Stata 10b. County		10c. City, To	wn or Locati	ion				1	0d. insida City Li
a or 28a-f show be notified at	tor	MD HARE	ORD	BELA	IR						1 ☐ Yas 2 ☐
or 28	Director	10e. Street and Number				10f. Zip Coda			10g. Citizan of	What Coun	ntry?
23a	<u>e</u>	1315 SWEETBRIA	R LANE			21014			US	A	
al', or ite		11. Marital Status 1 □ Navar Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Dacedan Armed Forcas d 1 ☐ Yas 2 K If Yas, Giva Yaar or Datas	?] No		as Dacedant of Hispanic Origin? (Specify Yas o Yas, specify Cuban, Maxican, Puarto Rican, atc. □ Yas 2ሺ No <i>Specify:</i>			Specify:		
natural',	ted	15. Decedant's	Education	16	a. Decedent	's Usual Occup	ation		16b. Kind of B		
then To We	Completed	(Specify only highest Elamantary/Secondary (0-12) 12TH GRADE	Collaga (1-4or		lifa. DO	d of work done of NOT usa ratired PERSON	during most of wor l)	king	RETAI	L SAL	ES
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nd Mental marked o matic eve	ToE	ALEXANDER TERAM	IANI				JEANET	TE DIG	IOVANNI		
and s m		19a. informant's Name/Ralationshi	(Type, Print)	19	b. Mailing A	ddrass (Streat	and Number or Ru	rai Routa Numi	ber, City or Town,	Stata, Zip	Code)
Department of Health Important: If Item 27 is any injury or other tre once.		CAROLYN RUTH	DAUG				IAR LANE	BELAIR	R, MD 2	1014	
F ite		20a. Mathod of Disposition Disposition Caramation 3	☐ Removel from State	on mod	of Disposition of Dis	on (Name of ory or other plac	e)	Data	20c. Location -	- City or To	wn, Stata
ant:		4 □ Donation 5 □ Othar (Spe		The state of the s	AND ME	EMORIAL	PARK 3	/30/2000	HILLE	NDALE	. MD
cian and burlal-transit	Examiner	rasulting In daath) Saquentially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disaase or Injury	b	Dua to (or as a Dua to (or as a	otic s	yndr	ame			1	4 m.
physicia as the bur	edical	causa, Enter Underfying Causa (Disease or Injury that initiated avants rasulting in death) Last	c	Dua to (or as a	consequan	ce of):					
0.10	Physician/M	Death Other death and the								İ	
8 4	hys	Part II. Other significant condition	contributing to death !	but not resulting	In the under	flying causa give	an In Part i.		Yee 2 No		the cause of de pably 4 ☐ Unk
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5.8	by							24a. Was	s an autopsy ormed?	cor	ara autopsy findly ailabla prior to
has been signer ge 2 should be d	by							perfe	s an autopsy ormed?	cor of c	ara autopsy findlr ailabla prior to mplation of cause
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certificate has been signer rector, page 2 should be d	Be Completed by	25. Was casa rafarrad to medical axaminar? 1 □ Yas 2 ☑ No	Hospital:	iant 2□ER/0	outpatient :	3□ DOA Othe		perfi 1 □ th (Check only	ormed? Yas 2⊠No ona)	ava cor of c	are autopsy findir aliabla prior to applation of cause death?
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					Cei	tificate	of E	Death			Reg. No.	0.	9939
ian	1. Decedent's Name (First, ROBERT	2 3 3 3 3 3 7 7		Tr.						2. Date of De Month March	17,2000	Year	3. Time of Death
cal	4a Facility Name (If not ins						41	b. City. Tow	n, or Lo	cation of Death			5:00P.M
ner	Sinai Hospit							Balti			10.00011	~/*	
	5. Social Security Number 217 82 1804 Usual Residence of Decede		7. M 2 F	Age (In yrs. I	last birthday) Yrs.	If Under 1 \ Months D	/ear leys	If Under 2	4 Hrs. Min.	8. Dete of Bir (Month, Da May 9	th y. Year) 1959	9. Birthp Coun 5. Cpa	lace (State or Foreign try) Kolina
Funeral Director	10a. State 10b. C			10c. City	BAL	cation TIMO	re				-	- 1	0d. Inside City Limits
	10e. Street and Number		P 1			10f. Zip Co					10g. Citizen of	Whet Cour	itry?
	2817 Wa					21.					20		
	11. Marital Status Never Married 2 3 Widowed 4 Div] Merried	12. Wes Deced Armed Forc 1 Tes 2 If Yas, Give Year or Del	es?		Vas Decedent Yes, specify		spanic Origi n, Mexican, Specify:	in? (Spe Puerto	ecity Yes or No Rican, etc.)	Specif	ce - Amaric ick, White, by: Bla	etc.
	15. Dec (Specify only	cedent's Educ	cation		16a. Deced	lent's Usuel O kind of work o	occupa	ition	of work	ina	16b. Kind of B	usiness/Inc	dustry
	Elementary/Secondary (0)-12)	College (1-4	or 5+)	life. L	NOT use T	etired)				Private		iners
100000000000000000000000000000000000000	17. Father's Name (First, M. ROBERT BA		n, SR.					_		MA H	heiden Sumer	ne)	
	19a. Informant's Name/Rela		1			-					er, City or Town		
	PEARLINE BY 20a. Method of Disposition	UNSM	1 5/57		28/7	_		orf pr	18	BATTUR	20c. Location		
	12 Burial 2 Creme 4 Donation 5 Oth		emovel from St	are	emetery, cren	sition (Name in the letory or other	r place	9)	3/	25 600			
	21. Signature of Funeral Se		10	114.	22	. Name and A	ddres	s of Facility	CH	ATHAN	J- HAR	Ris TU	Mary/mo
	desun	Har			5-	240 R	RI!	STERN	to w.	~ Kink	•	- 4	
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	disease or condition				r es e conseq	uence of):					713		
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year 120 Pp BAILE HARRIET MARCH 2000 20 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatt Ellicott City St. Agnes Nursing & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Dey, Year) January 28, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 10 M 20/F Pennsylvania 88 215-24-5798 Usual Residence of Decedent 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 XNo Maryland Ellicott City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A. 3005 Greenway Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black. White, etc. 1 Yes 2 LNO 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 M VMdowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry education Elementery/Secondery (0-12) College (1-4or 5+) teacher 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Marie Anna Zimmerman Bertam Hans Schwerdtfeger 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3005 Greenway Drive Efficott City, Maryland 21042 Mr. Roy Bailey 20b. Place of Disposition (Name of cemetery, crematory or other plece) Dulaney Valley Memorial Garden 3-24-00 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State Timonium, MD 4 Denation 5 Other (Specify) 21. Senature of Funerel Service Licansee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 levertler Ulas 140535 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Cardlovascular dere as Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Stage I wer failers 24b. Wera autopsy findings evailable prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Metural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and mannar as stated.

that the death certificate be executed P.O. Box 68760, Records, The law Division of Vital Physician: Attending

After this certificate r death. i or Attend after death Director: A d in by the f filled in by To the Hospital within 24 hours a To the Funeral C completaly filled

State Registrar

Physician

/Medical

Examiner

Funeral

Director

28s-f show must be notified at

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Items 23s

d 2 should be filed within 72 hours after do th and Mental Hygiene. 7 Is marked other than "natural", or frem traumatic event, the Houldal Exterioral.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tem 27 Is marked other any Injury or other traumatic event, phose.

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

been signed by should be detacl

Examiner

Physician/Medical

by

Completed

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Certification:

edical

21215-0020

Maryiand

Baltimore,

Director

Funeral

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Completed

the Maryland

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31. Date filed (Month, Day, Year) MAR 2 8 2000

LOP

29b. Signature and title of certifier

(Check only one)

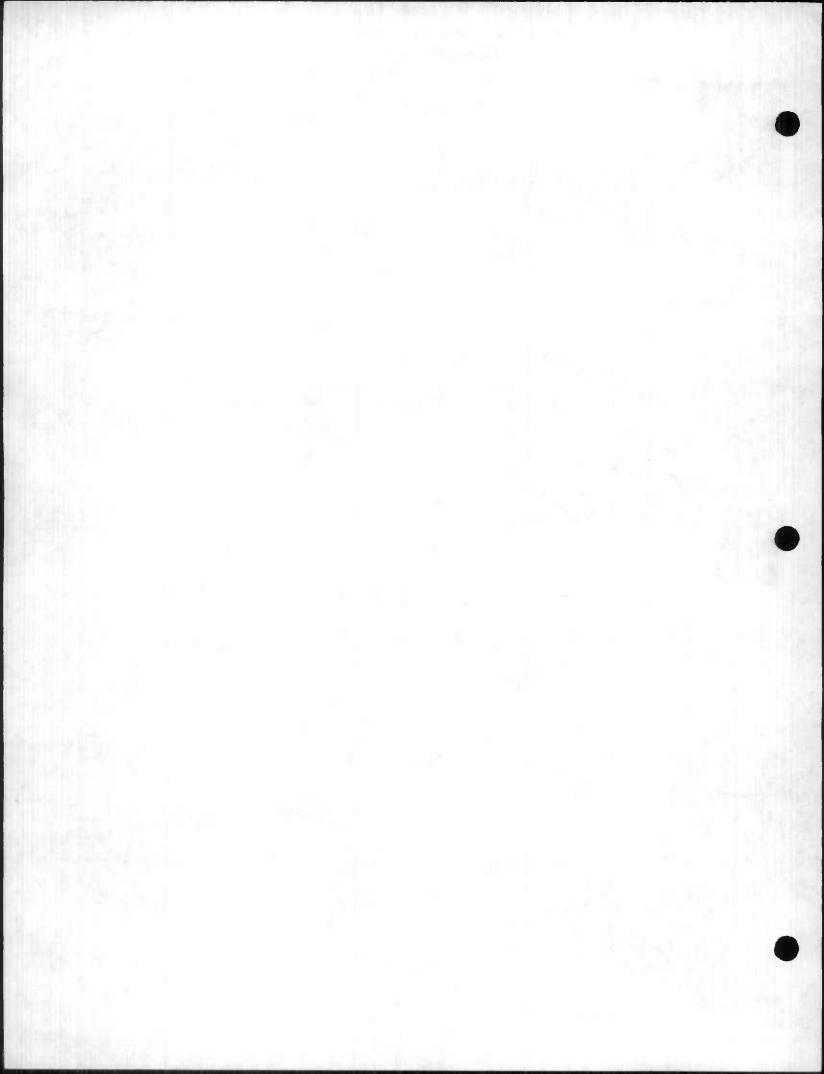
30. Nema and address of person who completed ceuse of death (Item 23a) (Type, Print) (Reisterstown, MD 21136)

25 man 32. Registrer's Signeture

29c. License number

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)



Items 23s or 28s-f show ther must be notified at

00

7. And (In vrs. last hirthday) **Funeral** Days Hours 101M 2□ F Months 69 Director 213 26 8880 Usual Residence of Deceder 10a. Stale 10b. County 10c. City, Town or Location Director BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 201 PATAPSCO AVENUE 21237 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Detes: 1949 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married nd Mental Hygiene.
marked other than "natural", or I
umatic evant, or Majora Error 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) CARPENTER 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental WILLIAM A. BROWN LUCY B. NORTH 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: if Item 27 le eny Injury or other trei phos. BETTY COLLISON BROWN/WIFE 201 PATAPSCO AVENUE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MAYS CHAPEL CHURCH CEM. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility
CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, 234. Page. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, and, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 4119 Examiner Examine Abdomina The law requires that the deeth certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf Due to (or es e consequence of): Box 68760. Physician/Medical physi the b Due to (or as a consequence of) 08n P.O. Pert ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Exposure, Sleep Aprex Records, Completed by ObsTRUCTIVE PalmonARY Disease of Vital or Attanding Physician: 25. Wes case referred to medical axaminer?

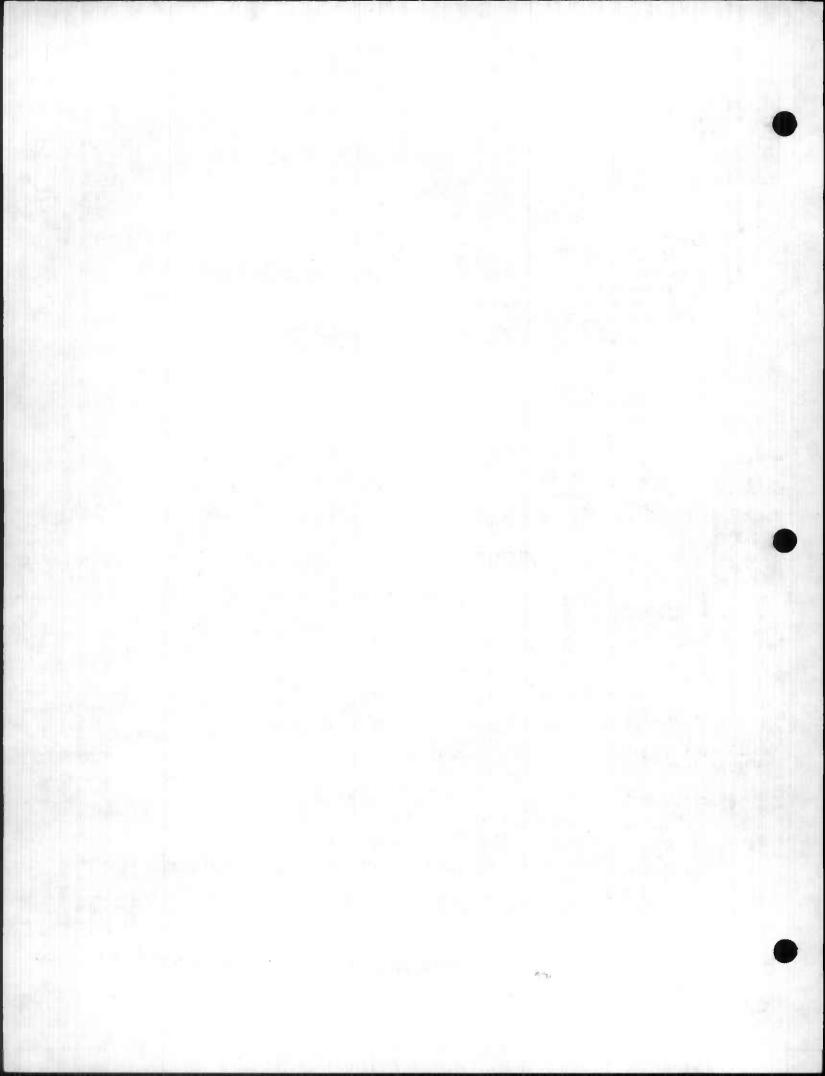
1 Yes 280 No 89 28. Piace of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Dete of Injury (Month, Day Year) Juneral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation Division within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital edicai 29e. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and addrass of person who completed cause of leath (frem 23a) (Type, Print) Aureung 9000 FRANKlin BALTIMORE, MARYLAND 21237 DR. KAMIUN SRUAR OR. 31. Date filed (Month, Day, Year) / MAR 2 8 32. Registrer's Signeture 2000 State

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** RAYMOND ROBERT BROWN MARCH 3:25 P.M. 23 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Hrs. 8. Date of Birth Min. OCT 27 STUARE Rose FRANKIN 5. Social Security Number HOSpilAl BAL (enler) IIMORE 9. Birthpiace (State or Foreign MARYLAND 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA Race - American Indien, Black, White, atc. Specify: WHITE 16h Kind of Business/Industry CONSTRUCTION 18. Mother's Neme (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BALTIMORE, MD 21237 20c. Location - City or Town, Stala 3/27/00 Timonium, MARYLAND Approximete Intervel Between Onset end Death MONTH 23b. Did fobacco use contributa to the causa of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

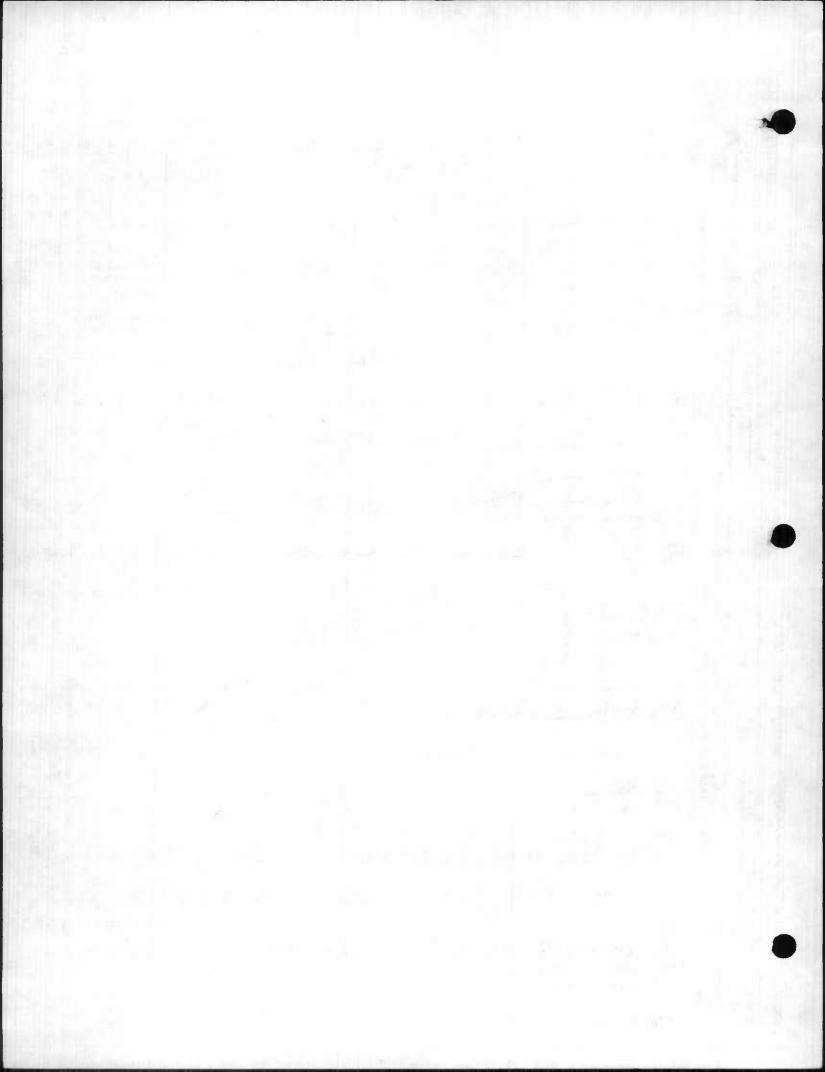
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 0 0 9 9 4 2

	1. Decedent's Name (F	irst. Middle 1 as	()		Ce	rtificate of	Death	2. Dete of D	Reg. No.		3. Tims of Death	
Physician			Carpen	ter				Month Mar.	Dev	Year	6:00am	
/Medical	4a Facility Name (If no						4b. City, Town, o	or Location of Dea			o.ooan	
	1616 N.	Bethel	Stre	et			Baltim	ore	N	IA		
Funeral Director	5. Social Security Numb 084-32-75	567	x □ M 2□x	7. Age (In yrs	. last birthday) Yrs.	Months Day			irth lsy, Year) L-40	9. Birthi Cou	place (State or Foreign ntry) VA	
D R s	Usual Residence of De 10a. State 10	b. County		10c. C	ity, Town or Lo	ocation				-	10d. Inside City Limits	
the Marylar r 28s-f show notified at	MD	NA		Ва	altimo	ore					1□ Yes 2□ No	
or 28 be not	10e. Street and Number					10f. Zip Code			10g. Citizen of	Whet Cou	ntry?	
4 2 H W	1010 N.	Bethel				2121			USA			
Maryland 21215-0020 42 should be flied within 72 hours after death and Merital Hygiene. 7 is marked other than "natural", or herns it naumatic event, the Medical Examiner my To Be Completed by Funer	Widowed 4 □		12. Wes Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		U.S. 13. Was Decedent of Hispanic Origin? ff Yas, specify Cuban, Mexican, Pue 1 □ Yes 2√2 No Specify:		(Specify Yes or Nerto Rican, etc.)		Race - American Indien, Bleck, White, etc.			
	15. (Specify of	Decedent's Edi	ication le completed)	cation 16a. Decedent's Usus e completed) (Give kind of wo life. DO NOT u.			upation e during most of v	vorkina	16b. Kind of B	usiness/In	dustry	
	Elementary/Seconda	ry (0-12)	College (1-40r 5+)				ed)		in h	ome		
			NA		nou				e, Maiden Sumer	n home		
			Randa	11			Juan		Hun			
any small	19a. Informant's Neme				19b. Meili	ng Address (Stree	et and Number or	Rural Route Numi	ber, City or Town	, State, Zij	Code) 11798	
Baltimore, Missens, semi. Pages I and 2 Appartment of Health a Apparament of Health and I have not help in highly or other transcore.	Lumelia	Turne	r				Street	Wheatl	ey Hei	ghts	, NY	
	20a. Method of Disposit 1 ☐ Burial 2 X C		Removal from S	Stete	cemetery, crei	sition (Name of matory or other p		Dete	20c. Location			
Itim flant	4 □ Donation 5 □			G							more, MD.	
Dem Department of the popular interportment o	21. Signature of Funera	Service Licens	500					altimor				
	23a. Part1. Enter the d shock, or heart fai	isbase, or comp ilure. List only o	licstions that ca ne causa on ea	aused tha dea ach line.	ith. Do not ent	er the mode of d	ring, such es card	iac or respiretory	errest,		Approximate Intervel Between Onset and Deeth	
Physician / /Medical	Immediata Causa (Fina	d.	= 0	01.00	C A.	· · ·				1		
Examiner	disease or condition resulting in death)		a. ESC	100		CAN	CER			i	5 Mourhs	
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To the comp	29b. Signature and title	of certifier				29c. Lice	nse number		29d. Date signe	ed (Month,	Day, Year)	
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State Registrar	31. Date filed (Month, D		32. Re	egistrer's Sign	1 do	no Va						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2000 MARCH 9:45 AM 24 JUDITH E. CROUSE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5818 FARMVIEW AVENUE RASPEBURG BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 XF Months 217 32 7473 62 JUNE 1. MARYLAND Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE RASPEBURG 10a. Street and Number 10f. Zip Code 10c. Citizen of What Country? 5818 FARMVIEW AVENUE 21206 USA 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) UNK. UNK HOPE CAVE 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5818 FARMVIEW AVE BALTIMORE, MARYLAND 21206 GEORGE CROUSE III / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 3/27/00 BALTIMORE, MD METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one cause on much line. Approximate Interval Between Onset and Death Immediate Cause (Final renal failure disease or condition resulting in death) 15 months Due to (or as e consequence of) renal disease endstage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of): diabetes mellitus Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cell carcinoma history renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? hypertension 1 Ves 2 No 1 Yes 2 No Cosonary artery diseas 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No

The law requires that the death certificate be assouted Box 68760, P.0.

physician s the burial for use as signed by the a funaral director. this To the Hospital or Attanding within 24 hours after death.
To the Funeral Diractor: After completely filled in by the fun.

Physician

/Medical

Examiner

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Funeral

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> 21 If of Health a If Item 27 is or other tra

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Physician /Medical

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Certification: To

Medical

27. Manner of Death

1. Natural

2 Accident

4 Homicide

29b. Signature and title of certifier

3 Suicide

Veronica

29a. Certifier (Check only one) 5 Pending investigation

6 ☐ Could not be determined

Deza My

Pages 1 and 2 should be nent of Health and Mental

the Maryland

hours after

Baltimore, Maryland 21215-0020

Division of Vital Records, or Attanding Physician:

DHMH 16 Rev 6/95

State Registrar

9101 Franklin Square 32. Registrar's Signature Deper

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

Svite 205

28c. Injury et Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

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28d. Describe how injury occurred

28f. Location (Street and Number or Flural Route Number, City or Town, State)

Balt, MD 21237

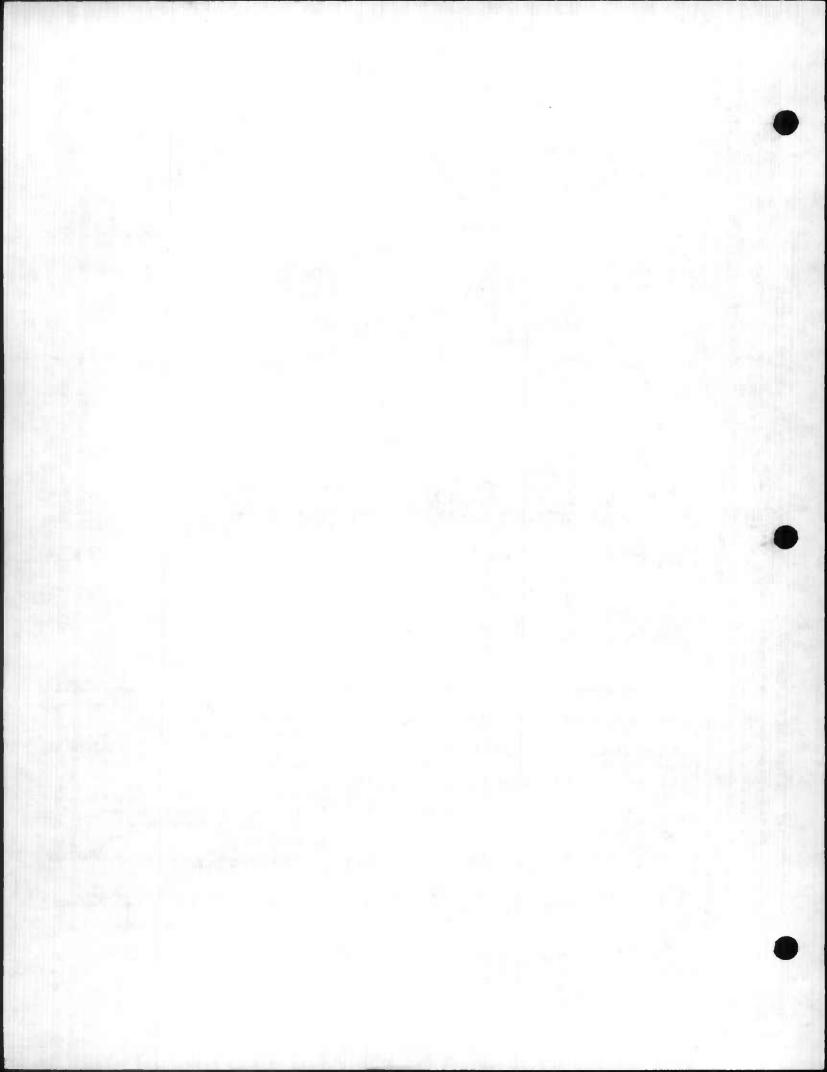
29d. Date signed (Month, Day, Year)

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28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

faculty instructo



Physician /Medical Examiner

Funeral

Director

ma 23a or 28a-f show Herman 6 the Medical Exa permit. Pages 1 and 2 should be the Department of Heelth and Mental Himportant: If Itam 27 Ia marked oft any Injury or other traumatic avar bioles. Pages 1 and 2 should be nent of Heelth and Mental

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Physician /Medical Examiner

P.O. Box 68760. the 980 ed by the a been signed is should be det Records, page 2 certificata Division of Vitai or Attanding Physician: funeral director, this after death. Director: Aft within 24 hours after To the Funeral Direcompletely filled in b Hospital

Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth March 26 Year 335 AM onnellu 1es DAY 2000 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Catonsville Baltimore Frederick Villa If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 M d 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 110-M 2□ F 220-20-0624 70 Yrs. 04 29 1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6721 Valley Creek Drive 21207 USA Funeral 14. Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status 1 Never Merried 25 Merried 1 Mayes 2 No If Yes, Give Year or Detes: 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Examiner Social Security 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be William L. Connelly Margaret Ritgert 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Levenia Connelly/wife 6721 Valley Creek Drive, Woodlawn, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Crem 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete Baltimore-Washington 03 29 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service License, 22. Name end Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 23a. Part. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 21228 Approximate Intervel Between Onset end Deeth Immediate Cause (Finel Cerebral Mism kosis diaeaae or condition resulting in death) diovascular decea Atheros clerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or es a consequence of): Pert If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ thknown 1 Yes 2 No þ Completed 24b. Were autopsy findings eveilable prior fo 24a. Wes en europsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospifal: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28h. Time of 28c. fnjury at Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29a. Certifier (Check only one) 29b. Signeture end fittle of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 1315872 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

ACUN BUB MO 25 MO 25 main St Newderdown 1 2/136 31. Dete filed (Month, Dey, Year) 32. Registrer'a Signeture State MAR 2 8 ZUUU

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State of Maryland / Department of Health and Mental Hygiene | |

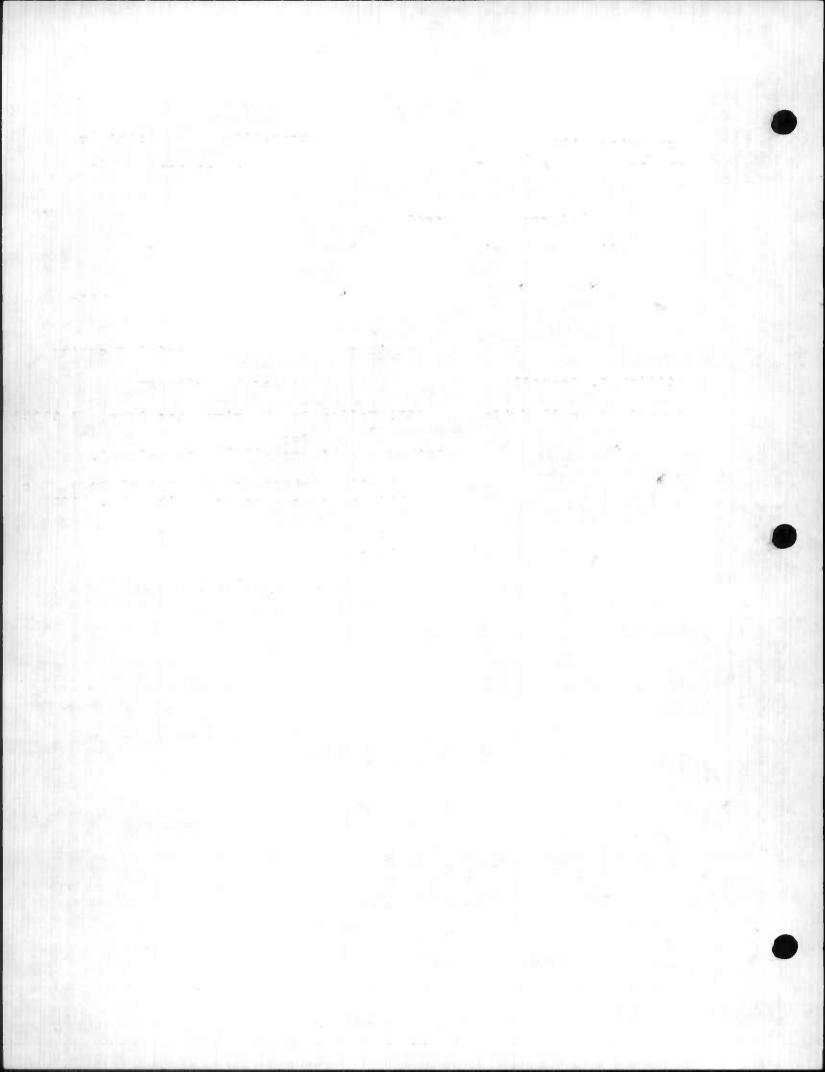
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To	19a. Informant's Name/Ralationship			19b. Mailir	g Addras	ss (Street				er, City or Town	n, Stata, Zij	21206
Injury or other	Francine E. Moore/Daughter 20a. Mathod of Disposition MXBuriat 2 Cramation 3 Char (Specify) MT ZION CEMETERY 22b. Placa of Disposition (Nama of cemetary, crematory or other placa) MT ZION CEMETERY 22c. Location - City or 1 23c. Location - City or 1 24817 Pleasant View Avenue, Baltimore, Management of Disposition (Nama of cemetary, crematory or other placa) MT ZION CEMETERY 22c. Nama and Address of Facility								- City or To	MARYLAND		
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ian cal ner	23a. Part T. Entar tha disaasa, or complications that ceused tha death. Do not antar tha mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disaas or condition a. MUTIPUE ORGAN S XTEM FAILURE									1	Onsat and Death	
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To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b Ö

State Registrar

DHMH 16 Rev 6/95

MARIO F. GOLLE 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura

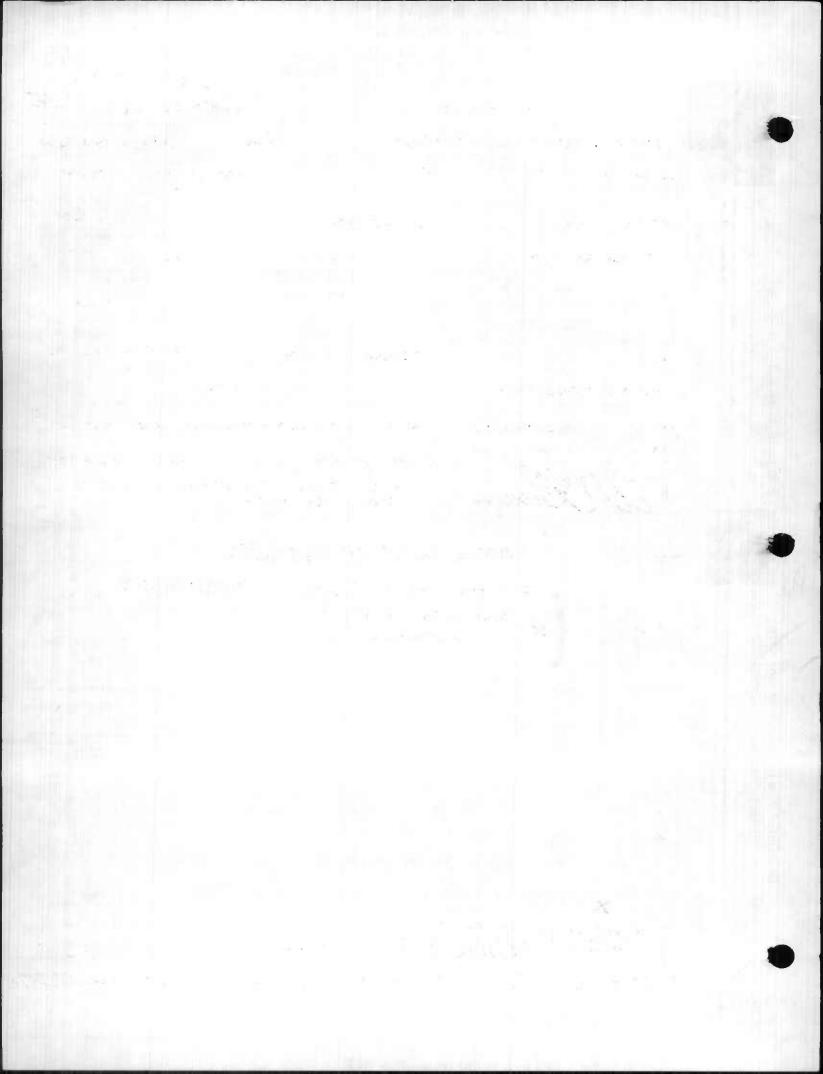
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29c. Licansa number

29d. Data signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09946 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death De **Physician** 06:27 SHIRLEY COLE - B
4a Facility Name (If not institution, give street and number) COLE - BECKER 20 MARCH 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner COUNTY GENERAL ITOSPITAL COLUMBIA HOWARN HOWARD 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 LF Hours Director 62 January 4, 1938 Maryland 213-38-5860 **Usual Residence of Decedent** the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director rs 23a or 28a-f a must be notified Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21043 3680- B Mt. Ida Drive U.S.A. Funeral 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 8 21215-0020 1 ☐ Yes 2 ☐No Specify: Specify: African American Hygiene. other then "natural", o ent, the Medical Exen þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Baltimore, Maryland 18 Mother's Name (First Middle Maiden Sumame) 17 Father's Name (First Middle Last) . Pages 1 and 2 should be the transit of Health and Mental Health and Mental Health and Mental Health larry or other traumatic aven 90 Stanley West Esther Savov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6652 Dove Coat Drive Columbia, Maryland 21044 Ms. Rosie Cole Collins Daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State White Rock Cemetery 03/24/2000 unation 5 []Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 m60535 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head feiture. List only one cause on each line. Approximate Intervel Between Onset and Death Physician nmediate Cause (Final isease or condition issulting in death) /Medical ACUTE MYOCARDIAL INFARCTION Hours Examiner Due to (or as a consequence of): Examiner DIABETES MELLITUS YENDS physician and the burlei-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): for use es signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No SLEEP APUEA , OBSTRUCTIVE OBESITY Records, Aq 24b. Were eutopsy findings available prior to completion of cause of death? cate hes been significant page 2 should b 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physicien: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No shis 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investige 1 Yes 2 No

After Attending 8

funeral director. Division filled in by

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Puneral Director: Aft Hospital To the Hosp within 24 hor To the Fune completely fl

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Registrar

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30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

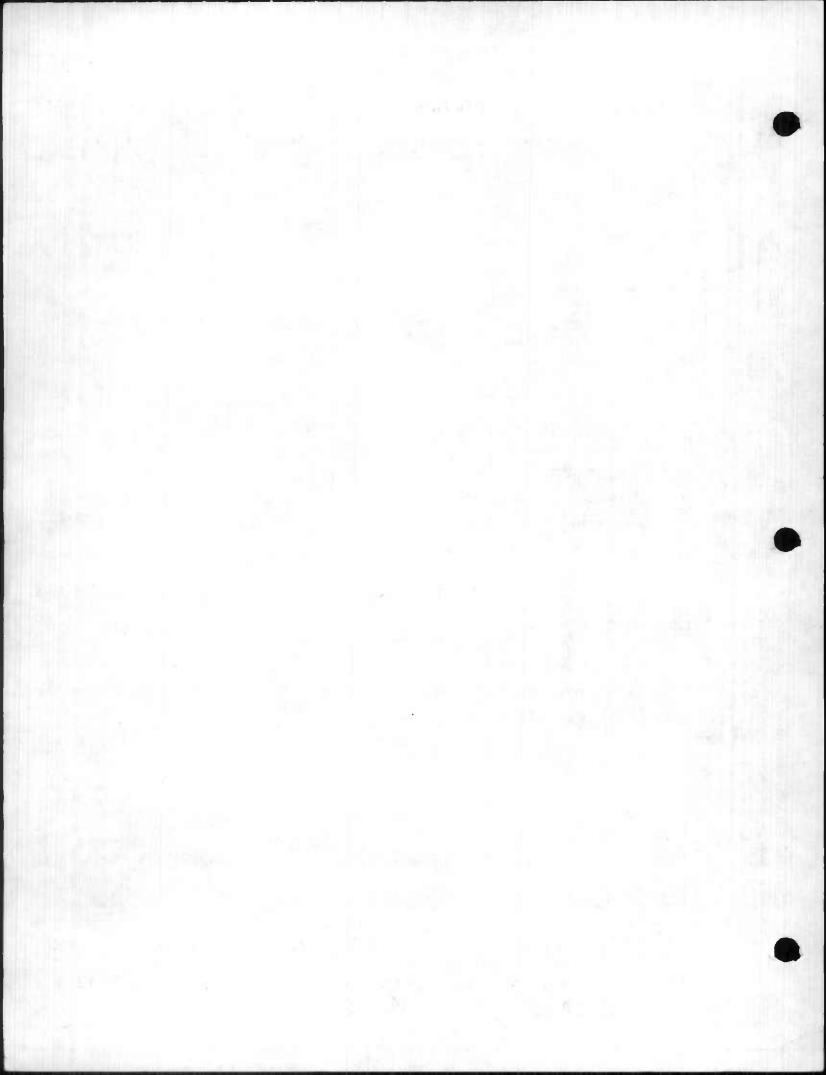
29c. License number D 38296

GIBBONS MD 9501 OLD ANNAPOLIS ED, ELLICOTT CITY, MD 21042

281. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MARCH 20, 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** March 26, 2000 Ethel Marie Clark /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 11211 Thompson Ave. Reisterstown 8. Data of Birth (Month, Day: Y 5. Social Security Number 220-68-3067 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 F Months Mary Pand 88 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10e State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No Maryland Baltimore Director Reisterstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Mous Leanne.

'Mental Hygiene.' natural', or frema 23a or 'marked other than "natural", or frema 23a or 'marked other than be I 21136 U.S.A. 11211 Thompson Ave. Funeral death 13. Was Decedent of Hispanic Drigin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, atc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker Baltimore, Maryland 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be 1 nent of Health end Mental I Sugan Forsyth Arthur Tinkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) of Health e 11202 Thompson Ave. Reisterstown, Md. 21136 Barbara Clark permit. Peges 1 and Department of Health Important: If Item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Degrial 2 Cremation 3 Removal from State DeerPark Church Cem. March 29,2000 Reisterstown, Md. 4 ☐ Donafion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatura of Funeral Service Licenses Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Daath **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consequence of) Physician/Medical Examiner Sclerotio attending physician and for use as the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. the death certificate be Due to (or as a consequence of): 23b. Did tobacco use contributs to the causs of death2-P.O. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown 6 þ Records, 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No certificate of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examine? Hospital: Othar: 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera After Division 1 Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Corifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titleyof certifia 29c. License number 29d. Data signed (Month, Day, Year) arle 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) MME 1/11 31. Date filed (Month, Day, Year) 32, Registrar's Signature

State Registrar

MAR 2 8 2000

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Isiaha Deanndre Dorsev AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Physician
/Medical
Examiner

Isiah De'Anndre Dorsey

1. Decedent's Neme (First, Middle, Last)

2. Date of Death 2000 Month March 26,

3. Time of Death 920 pm

1 ☐ Yas 2 No

Funeral

Director

natural, or hams 23a or 28a-f show Directo Funeral à Completed Hygiana. Be

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parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important. If New 27 is market any injury or

Baltimore, Maryland 21215-0020

68760

Box

D.O.

of Vital Records,

Division

Physician /Medical Examiner

Examine Bud physician certificata be Physician/Medical the 88 attanding the signed by þ Completed has To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific Be 10 Certification:

4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Baltimore Essex Franklin Square Hospital If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Houra 1 M 2 F Montha Days Yrs Maryland 01-14-2000 Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limita Baltimore Essex 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Tace Drive #1A 21221 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marifal Status X Never Married 2 Merried 1 ☐ Yea XXNo Black Specify: If Yes, Give Year or Detes: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None N/A 0 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Ibrahim Adisa Dorsey Markeisha Deshaun Dawson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent'a Neme/Reletionship (Type, Print) Markeisha D. Dorsey (Mother) 1110 Tace Dr. #1A Essex Md. 21221 20b. Plece of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete Loudon Park Cemetery 3/30/00 Balto., Md. 21229 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Caple Funeral Service Balto., Md. 21215 Jennis B. (5502 Winner Ave. 23e. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one cause on each line. SUDDEN UNEXPLAINED DEATH IN INFANCY ASSOCIATED WITH Immediete Causa (Final disease or condition resulting in deeth) a GRANULAMATOUS INFLAMMATION OF THE LUNGS Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequence of)

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings aveilable prior to completion of cause of death? 10 Yas 2 No

Approximete Intervel Between Onset end Deeth

25. Wes case referred to medical examiner?
1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

Could not be determined

28e. Dete of Injury (Month, Day Year) 5 Pending investigation

3-26-00 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of A Injury 8:55

RESIDENCE

28c. Injury at Work? 1 ☐ Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred UNKNOWN

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1110 TACE DRIVE, APT 1A, BALTIMORE, MD. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as atated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, due to the cause(s) and manner as atated.
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29b. Signeture and title of certifier

27. Menner of Death

1 Neturel

2 Accident

3 Suicide

29e. Certifier (Check only one)

4 Homicide

29c. License number O.C.M.E.

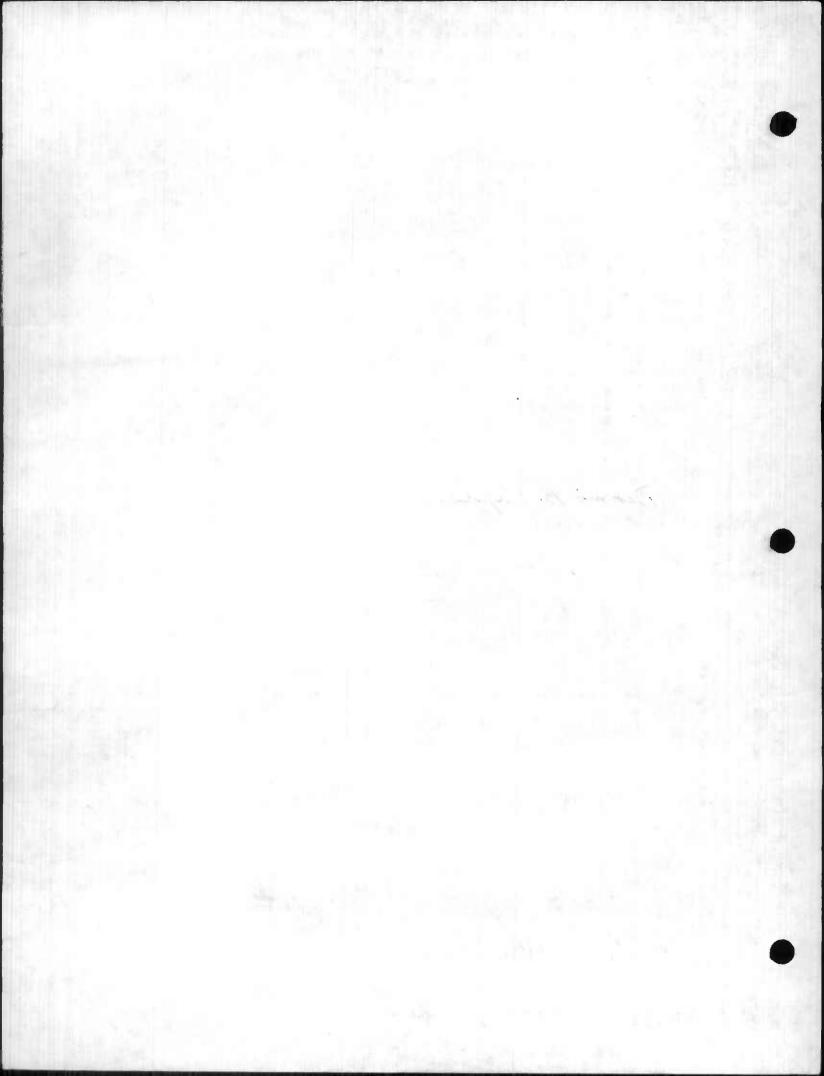
29d. Dete aigned (Month, Day, Year)

March 27, 2000

no 30. Name and address of person who completed cause of deeth (flem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Registrar



_	Decedent's Name (First, Middle, La	st)	Cer	tificate of	Death	2. Date of De	Reg. No.	3. Tim	a of Death		
Physician /Medical	Jane Dettmer					March	20°, 20		25 pm		
Examiner	4a Facility Name (If not institution, give	e street end number)			4b. City, Town, or I	ocation of Deat	h 4c. County	of Deeth			
Funeral Director	Maria Health Ca 5. Social Security Number 6. S		If Under 1 Year Months Days		8. Dete of Bir (Month, De	rth sy, Year)	9. Birthplace (St. Country)	ete or Foreign			
Director	219-66-1840 Usual Residence of Decedent	8	7			Mar.	19, 191	3 MD			
aytan thom	10a. State 10b. County		City, Town or Lo	cation					le City Limits		
vith the Ma t or 28s-f s be notified Director	MD Baltimo	ore I	Baltimo	T-					Yes XX No		
after death with the Maryla or Herre 23s or 28s-f show miner must be notified at Funeral Director	6401 North Char	cles Street		10f. Zip Code	21212		10g. Citizen of W				
D	11. Maritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 27 No 14 Yes, Give Year or Dates:		Ves Decedent of I Yes, specify Cub □ Yes XIXNo	Hispanic Origin? (S ean, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - American tndia k, White, etc. White	n,		
ed within 72 to ygene. we then "naturn it, the Medical."	15. Decedent's Ec (Specify only highest gra Elementery/Secondery (0-12)	ducation ide completed) College (1-4or 5+) 5 +	(Give	lent's Usual Occu kind of work done DO NOT use retire	rk doné during mast of working se retired)				2001		
Hyginat and a Co	17. Father's Neme (First, Middle, Last,		100	actic1	18. Mother's Nan	ne (First, Middle	, Meiden Surnem		1001		
Mental H missed oth file even To Be	William Dettmer				Kath	erine (Schroen				
and h	19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number										
and m 27 m 27	Bernice Feiling		6401	N. Ch	arles S		ltimore	, MD 21	212		
Pages nert if he ary or of	20a. Method of Disposition Durial 2 Cremetion 3 C Application 5 Other (Specification)	and the second	Place of Dispo- cemetery, crem 7illa N	netory or other ple	emetery	3/23/00		City or Town, Stell Arm, MI			
Departi Departi Importa any inji	21. Alchature of Funerel Service Licenses 22. Name and Address of Fecility Mitchell Wiedefeld Home 6500 York Road, Baltimore, MD										
Physician	23a. Part1. Enter the diseese, or com shock, or heert failure. List only	plicel on that caused the decone cause on each line.	eth. Do not ente	or the mode of dyi	ing, such as cardiac	or respiretory e	prrest,	Approx	imete Between end Death		
/Medical Examiner	tmmediete Cause (Final disease or condition resulting in deeth)	b. myoranel	for as a conseq	for lun	e		-	52	years		
tificate be executed to physician and as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	Due to	(or as a consequence of the cons	uence of):	~			70	years		
attending for use as clan/Me		d					1				
y the	Part II. Other algorificant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause gi	ven in Part I.		ild tobacco use contributa to the cause of death				
aw requin							an autopsy ormed?	24b. Were auto available p completior of death?	rior to		
Page Con						10	Yes XXNo	1 🗆 Yes	2□ No		
Physician: this certific ral director, TO Be	25. Was case referred to medical examiner?	Hospital:		0	26. Place of Dec						
ng Physic frer this o uneral din on: To	1 Yes MNo 27. Manner of Death 1 Neturel 5 Pending	28e. Date of tnjury (Month, Dey Year)	28b. Time of Injury	28c. tnju	ny et ork?		idence 6 Other how injury occurr				
To the Hospital or Attending Physician: The is Whinis 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident investigation 3 Suicide 6 Could not be determined		home, ferm, stri		Yes 2□No	28f. Location (Street and Number or Rural Route City or Town, State)			Number,		
To the Hospital or J Within 24 hours after To the Funeral Dire completely filled in b Medical Certi	29a. Certifier (Check only one) Certifying Ph	yatcien: To the best of my kn niner: On the basis of examinand menner steted.	nowledge, deeth netion and/or inv	occurred et the ti estigetion, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma date end plece, a	nner as stated. and due to the cau	use(s)		
Me Me	29b. Signeture end title of certifier	0.		29c. Licen	se number		29d. Date signer	(Month, Day, Ye	ar)		
	Illandi C.	Clinstuns		DS	54937		3/21/0	TV UT			
ON	30. Neme end address of person who		em 23a) (Type, I	Print)			1				
01	Martin C. Clows	e, M.D., 65	65 N.	Charles	s St., 1	owson,	MD 21:	204			
State Registrar	Martin C. Clows 31. Dete filed (Month, Dey, Year) MAR 28	32. Hegistrar's Sign	65 N.	Charles	s St., 1	lowson,	MD 21	204			

DHMH 16 Ray 6/95

Kennis Soft of Bucker

State of Maryland / Department of Health and Mental Hygiene 0 0 9 9 5 0

	Certificate of Death	Reg. F	No.		
Physician		Date of Death Month	25 200	3. Time of Death	
/Medical Examiner	Carl Anderson Durkee M 4a Facility Name (If not institution, give street and number) Copper Ridge 4b. City, Town, or Location Sykesyl	on of Death	4c. County of De	eath	
Funeral Director	5. Social Security Number 6. Sex 10 M 2 F 7. Age (In yrs. last birthday) 11 Under 1 Year If Under 24 Hrs. 8.1 Months Days Hours Min. Au	Date of Birth (Month, Day, Yea	9. B	Sirthplace (State or Foreign Country) Ksville, N.Y	
N N	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
or 28s-t show be notified at Director	Md. Baltimore Marriottsville		1 Yes 2 XN		
ust be na ral Dire	10e. Street and Number 10f. Zip Code 21104	10g. Cilizen of What Country?			
Examiner must be by Funeral Di	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Norvorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto Rica It Yes, Specify Cuban, Mexican, Puerto	Yas or No- in, etc.)	14. Race - Ar Bleck, Wi	merican Indian, hite, etc.	
dical	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Busines	ss/Industry	
Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) College (1-4or 5+) Attorney 18. Mother's Name (Fi		Legal		
To Be	Francis M. Durkee Edith Hi		on ourname)		
-	19a. Informant's Name/Relationship (Type, Print) Eric Durkee - Son 19b. Meiling Address (Street end Number or Rural Ro				
ny or other t	1 M Burist 2 Commettee 2 Demonstrate State cemetery, cremetery or other place)		Location - City Randal	or Town, State	
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	25. Was cese referred to medical 26. Place of Death (C	1 Yes	2 0 No	1 ☐ Yes 2 No	
After this funeral di	axaminer? 1	5 Residence Describe how in	njury occurred	pecity) Rurel Route Number,	
Minn 24 hours energeen: To the Funeral Director: A completely filled in by the f Medical Certificati	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and some place in the basis of examination and/or investigation, in my opinion, death occurred a end manner stated.	due to the ceuse at the time, date	e(s) and mannar and place, and o	as stated. due to the cause(s)	
To the	29b. Signature and title of certifier Dight MD 29c. License number D 52740			2000 2000	
State Registrar	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) EINESTINE WIGHT COPPERRIDGE, 710 OBRECHT 31. Date filed (Month, Day, Year) MAR 2 8 2000 MAR 2 8 2000 Appendix	ROAD	SYKES	VILLE, MD 2178	

State of Maryland / Department of Health and Mental Hygiene 00 09951

	Certificate of Death	Re	ig. No.	16660					
Dharataina	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death					
Physician /Medical	JUNE DAVIS	MARCH	24 2000	0359					
Examiner	4s Facility Name (If not institution, give street and number) 4b. City, Town	n, or Location of Death	4c. County of Deat	h					
		ALLSTOWN	BALTIMOR	RE					
Funeral Director	5. Social Security Number 219-26-2241 G. Sex 1 Months Days Hours 63 Yrs. 63 Yrs.	4 Hrs. 8. Date of Birth (Month, Day, 6-18-19	Year) Co	hplace (State or For untry) MD •					
natural; or items 23s or 28s-f show likel Examiner must be notified at sted by Funeral Director	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lin					
or 28e-fa	MD. BALTIMORE RANDALLSTOWN								
Dir	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co								
23 m	2020 FEATHERBED LANE APT 304 21207		USA						
al, or flame 23a or 28a-f ahow Familiar mant be notified at by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin If Yes, apecify Cuban, Mexican, If Yes, apecify Cuban, If Yes, apecify	Puerto Rican, etc.)	14. Race - Ame Black, White Specify: BLA	e, etc.					
"natural", affect En	15. Decedent's Education 16a. Decedent's Usual Occupation	1	16b. Kind of Business/	Industry					
	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	N WORKING							
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d other event. Be Cc	17. Fether's Name (First, Middle, Last) 18. Mother's	s Name (First, Middle, M	laiden Sumame)						
To E	GEORGE HICKS GL	ORIA GREEN							
27 le mer troum	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 2020 FEATHERBED L								
Department Important: I any Injury o	4 Donation 5 Dother (Specify) GARRISON FOREST VETERAN 21. Significant Poweral Service Lice (See) 1721-27 N. MONRO	PHILLIPS FU	NERAL HOME	E, P.A.					
Redical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibated events resulting in death) Last LARPIOPULMO NARY ARREST Due to (or as a consequence of): Due to (or as a consequence of): AMD Due to (or as a consequence of): AMD Due to (or as a consequence of):								
isigned by the attending to be datached for usa d by Physician/N	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld tol	bacco use contribute	to the cause of de					
should be d		24a. Was ar	ned?	Were autopsy findir available prior to completion of cause of death?					
page 2		1□ Ye		1 ☐ Yes 2 ☐ No					
# o	25. Was case referred to medical 26. Place of	of Death (Check only one							
	examiner? Hospital: Other	sing Home 5 Reside		citv)					
67	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 2 Accident investigation 1 Vest 2 No.	28d. Describe ho							
al Director: After the In by the funeral Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,					
n 24 nour he Funer pletaly fill edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth and manner stated.								
To the	290. Someture and title of ceptilier 29c. License number		9d. Date signed (Mont	h, Day, Year)					
	Hoof 133	51	March 29, 200						
9	1 100 POV	1. Samalst	Cun con	21133					
State	31. Date filed (Month, Pey, Yeer) 2000 32. Registrar's Signature	- dryschorz	N-01 (-6/1)						
Registrar	MAR 2 0 2000 Serene G. Sparke								

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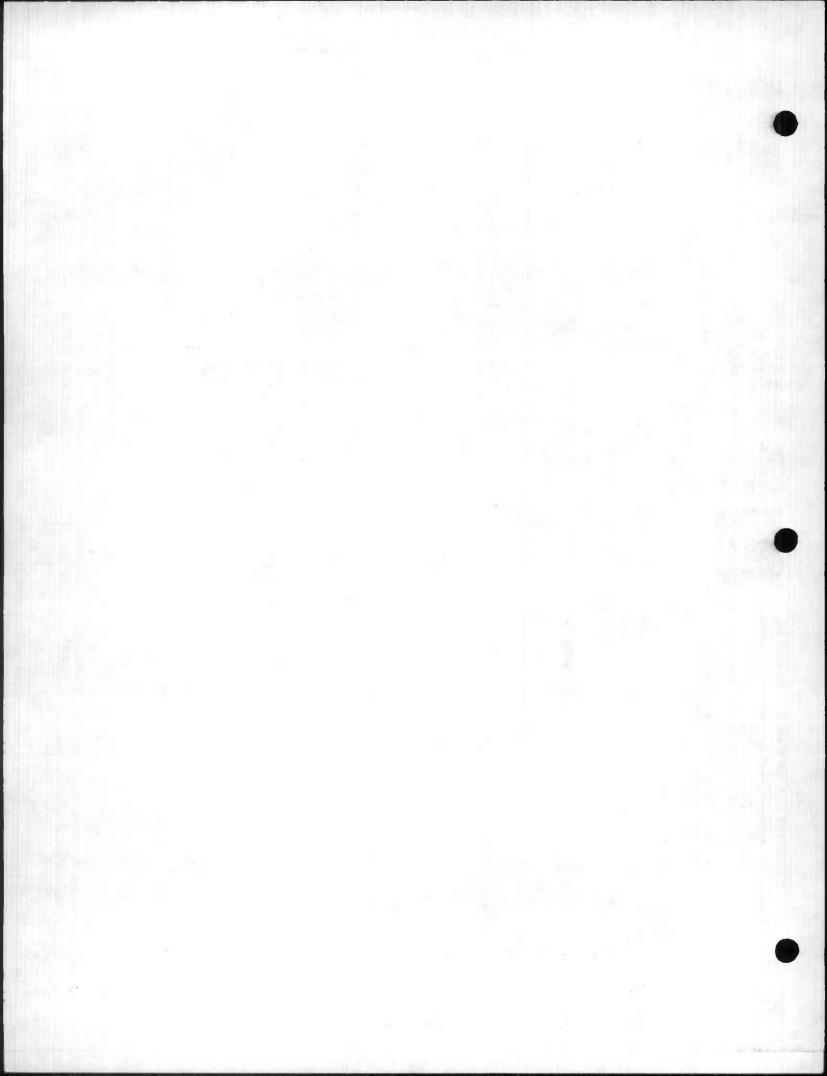
Tental Late materials.

END UNDER STEEL BEINDE BEINDE BERNELLEN

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** Eline 23 March 711 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balti move Citu Baltimore City Bayview Medical Johns Hookins
5. Social Security Number Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar 6 Say 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 20 F Months Days 78 Director 217-16-1167 Maryland Usual Residence of Decedent the Manyland 10a. State 10b Count 10c. City. Town or Location 10d. Inside City Limits mast be notified at Baltimore County Baltimore Maryland 1 Yes & No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 21237 1833 Hanford Rd. USA Funeral Nema 2 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? the Medical Examiner filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Datas: WW11 6 1 Yas 2 No Specify: 21215-0020 à Specify 3 ☐ Widowed 4 ☐ Divorced netural". White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Analyst 12 yrs. 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surnama) Pages 1 and 2 should be finant of Health and Mental I Charles H. Eline Sr. Bernita C. Woolford 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other trains Mrs. Mary C. Eline (Wife) 1833 Hanford Rd. Baltimore. Md. 21237 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny Injury or page. Metro Crematory, Inc. 3-27-00 Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence ot) for use as signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yas 20 No 3 Probably 4 Unknown à 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 🗆 Yas or Attending Physician: 25. Was case reterred to medical examiner? Certification: To Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 (Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Netural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 ☐ Suicide 8 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, atreet, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(a) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the the 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifian 30. Name and address of person who completed cause of death (Item 23a)/(Type, Print) BAYVIEW MEDICAL HODK NTONIA JOHNS 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 8 2000

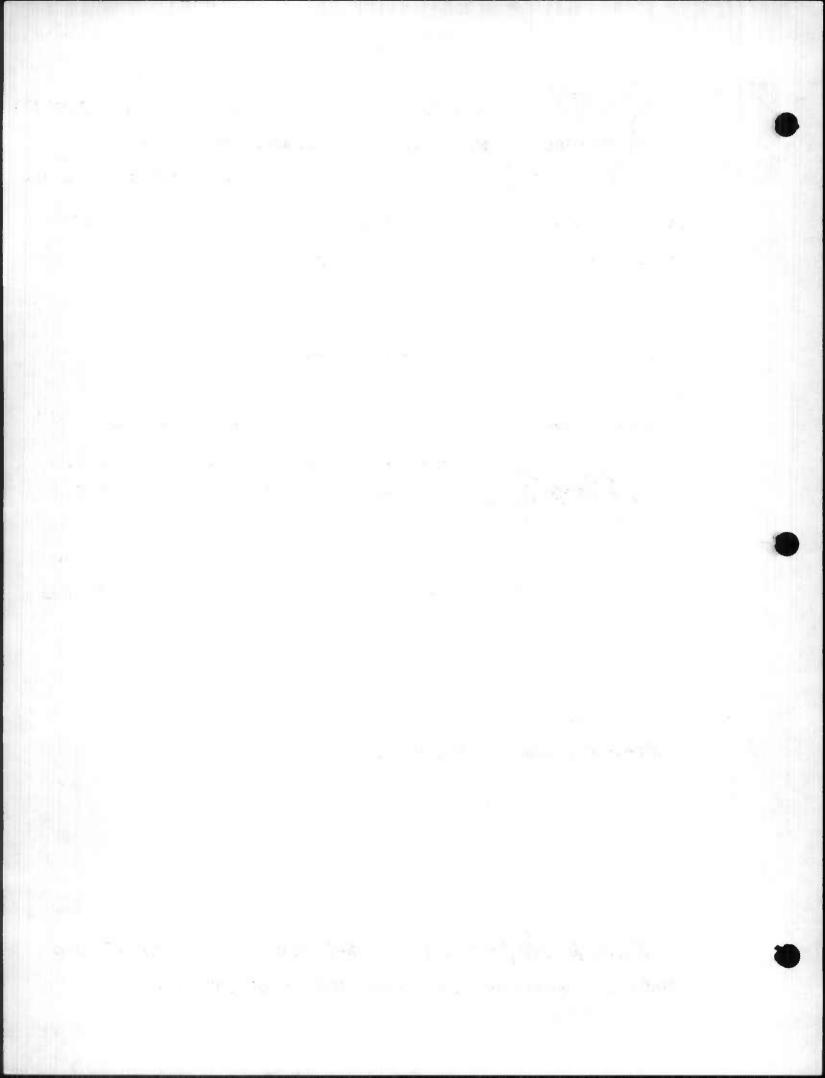


State of Maryland / Department of Health and Mental Hygiene

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Jam.		THOMAS EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or						per, City or Tow	ly or Town, Stete, Zip Code)						
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within 24 hours after death. To the Funerel Director: After this or completely filled in by the funeral director. Medical Certification: To	2	1 ☐ Yes 2 ☐ No			2 ER/Outp		3 DO	^		rsing Hom	na 5□ Res	idence 6 🗆 C	ther (Specifi	y)	
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		3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, Stata)							
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant'a Name (First, Middla, Last) 2. Data of Death 3. Tima of Death March Day Year **Physician** Bernard Lee Fowlkes, Sr. L: OSPM 241 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NA Union Memorial Hospital If Under 24 Hrs. If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 05-16-33 Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days XXM 20 F Months Hours Yrs. 228-38-6355 66 VA Director Usual Rasidence of Decedani death with the Maryland 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ahon traumatic event, the Medical Examiner must be notified at Yas 2 No Baltimore MD NA Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 USA 21205 1311 E. Eager Street Herna 23a 12. Was Decedant Ever in U,S. Armed Forcas? 1 X Yas 2 ☐ No If Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yaa or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of health and Mental Hygiene. Important: If them 27 is marked other than "naturel", or frem any injury or other traumatic event, the same once. Black, Whita, etc. 1 Nevar Married 2 Married 1 Yaa 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant'a Education (Specify only highest grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Armco Steel Co. Steel Worker 10th Grade 17. Fathar'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Miller Lorraine Unknown 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1311 E. Eager Street Baltimore, MD 21205 Fowlkes Gloria 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata MD. 1 Burial 2 Cramation 3 Ramoval from Stata Garrison Forest VA Cem. 03-30-2000 Owings Mills 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, Maryland 21202 21. Signatura of Funeral Service Licensee 22. Nama and Addrasa of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. WM.C.March FH 1101 E. North Avenue Approximata Interval Batween Onset and Death **Physician** /Medical immediata Causa (Final disaaaa or condition resulting in daath) suspected pulmonary embolus Smeratis Examiner Due to (or as a consequence of) Physician/Medical Examiner SUNIS The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata ceusa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last the attending physician and hed for use as the burial-tran Dua to (or as a consequence of): Box 68760. NUMBER Due to (or as a consequence of) P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? yd bengis need 1 Yaa 2 No 3 Probably 4 Unknown Sims, Division of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed Dementin 24a. Waa an autopsy performed? this certificate has 1 Yes 2 No 1 Tyes 2 No tal or Attending Physician: The after death. St Director: After this certificated in by the luneral director, pa Be 25. Was casa rafarred to medicel examinar? 26. Place of Death (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) Medical Certification: To Inpatiant 2 ER/OutpatienI 3 DOA 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 1. Natural 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding invastigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) To the Hospital or Atterwithin 24 hours after dee To the Funeral Director Completely filled in by the 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. 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Registrar

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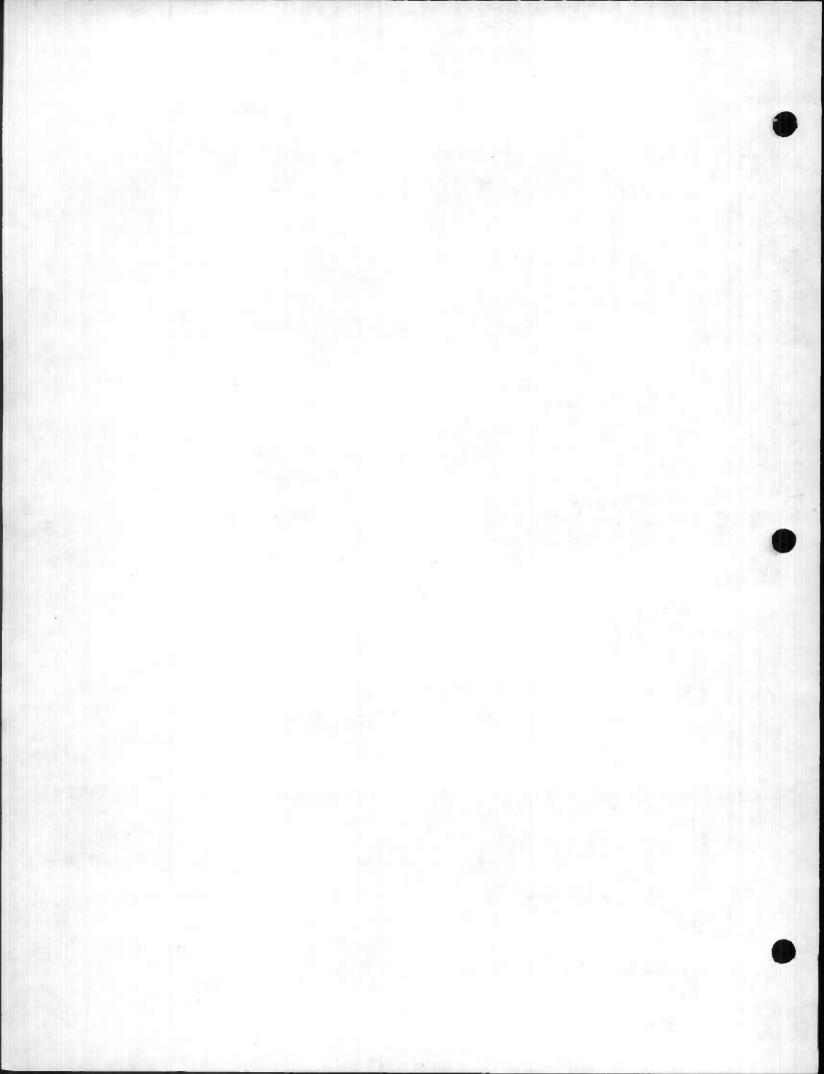
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32. Registrar'a Signeture

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

31. Dete filed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death D 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** 130 25, 2006 4c. County of Death /Medical BALTIMORE
If Under 24 Hrs. 8. Dete of Birth
Adoptio, Day, y 4a Facility Name (# not institution, give street and number) Examiner ANION HARBOK If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 M 2 F 213-32-1756 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 526 ULDIN 21224 5. Funeral 12. Wes Decedent Ever in U,S. Wes Decedent of Hispanic Origin? (Specify Yes or No-il Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 14. Rece - American Indian permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Item eny Injury or other treumatic event, the Medical Experiments. Armed Forces?

1 Yes 2 No
If Yes, Give Bleck, White, etc. 1 Never Memed 2 Memed 1□ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ROV LEE FELTNER SPRIGES 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) RUBV 526 S. BOULDIN ST. BALTIMORE, MD. 21224 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other p MARAH 29 Date 20c. Location City or Town, Steta 1 Buriat 2 ☐ Cremetion 3 ☐ Removel from Stefe CARMEL CEM. 4 ☐ Donation 5 ☐ Other (Specify) 2000 21. Signature of Funeral Service Licenses 22. Neme and Address of Fecility MD 21224 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finel LUNG DISEASE End STAGE 1 day disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No None Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy parformed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2BNo To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00

State Registrar

DHMH 16 Rev 6/95

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i

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Division of Vital

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Baitimore, Maryland 21215-0020

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31. Date filed (Month, Day, Year)

32. Registrer's Signeture Geneva

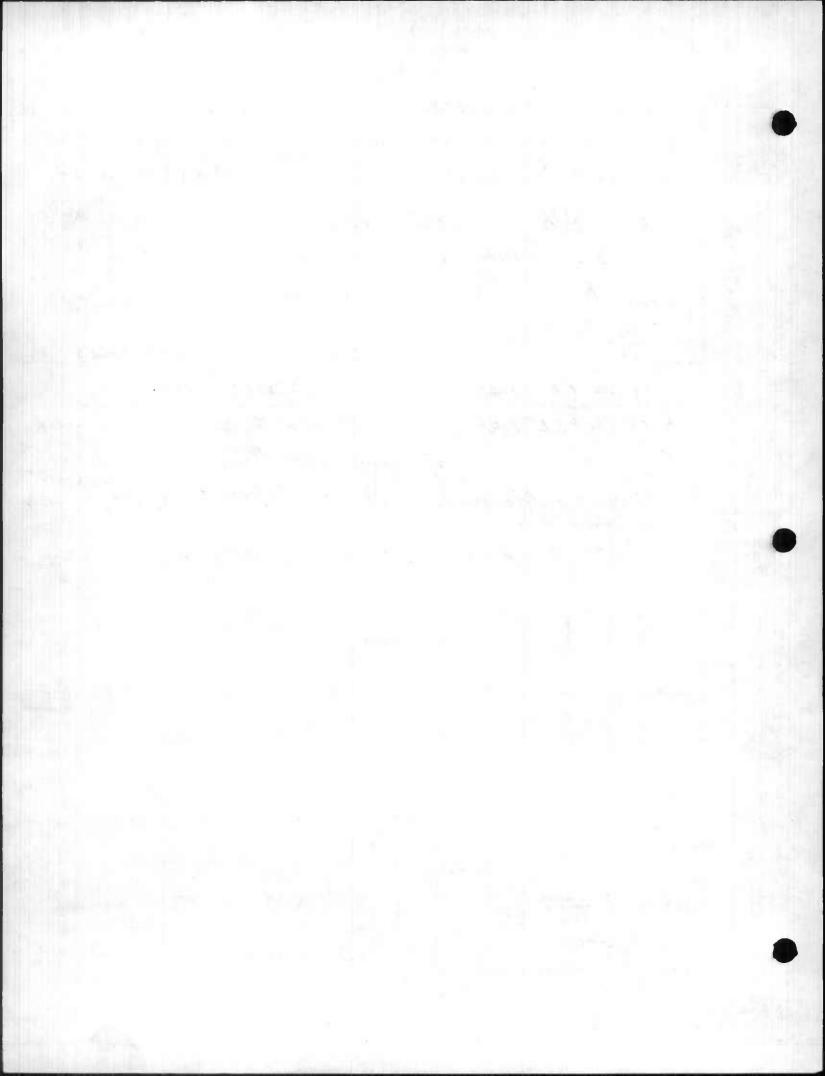
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

201-109 BACK RIVER NECK RD.

-05 4636

MD 2/221

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09956 Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year FERTITTA JOHN SA 25 march 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death GENERAL HOSPISAL E ALLSTON FALLSTON HAZFORD 8. Data of Birth (Month, Day, Year) NOV • 24 1928 If Under 1 Yaar | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 1 ☑ M 2 □ F Yrs. 217-22-0738 71 Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d, fnsida City Limits Md Baltimore Baltimore 1 ☐ Yas 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4223 Chapel Road 21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 1⊠ Yas 2 □ No If Yas, Giva 11. Marital Status 14. Raca - Amarican Indian, Black, Whita, atc 1 Nevar Married 2K Married 1 ☐ Yas 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grads completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Laborer City of Baltimore 8th 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Anthony Fertitta Rose Cinguegrani 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Sharon Wells /daughter 316 Torner Road Baltimore Md. 21221 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata t Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Parkwood Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 3/28/2000 Baltimore MD 21. Signature of Funaral Sarvice Licansee 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List by one cause on each line. Approximata Interval Batween Onset and Death Immediata Causa (Final diaaaaa or condition rasulting in death) SEPSIS Dua to (or as a consequence of): PNEUMONIA BILATERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequenca of): HON HODGKINS Dua to (or as a consequance of): Part II. Other algorificant conditions contributing to death but not reaulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yaa 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENSION 24b. Wara autopsy tindings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 200 No 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2□ No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homloida 29a. Certifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the deeth certificate be executed ۵. of Vital Records, or Attending Physician: Division death.

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use as t hes funeral director. After after death the filled in by To the Hospital o within 24 hours at To the Funeral Di completely filled in

State Registrar

DHMH 16 Rev 6/95

SPRABHU 31. Data filed (Month, Day, Year) MAR 2 8 201 2000

29b. Signatura and titla of certifiar

728 BERAR MD MO 32. Registrar's Signatura

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

29c. License number

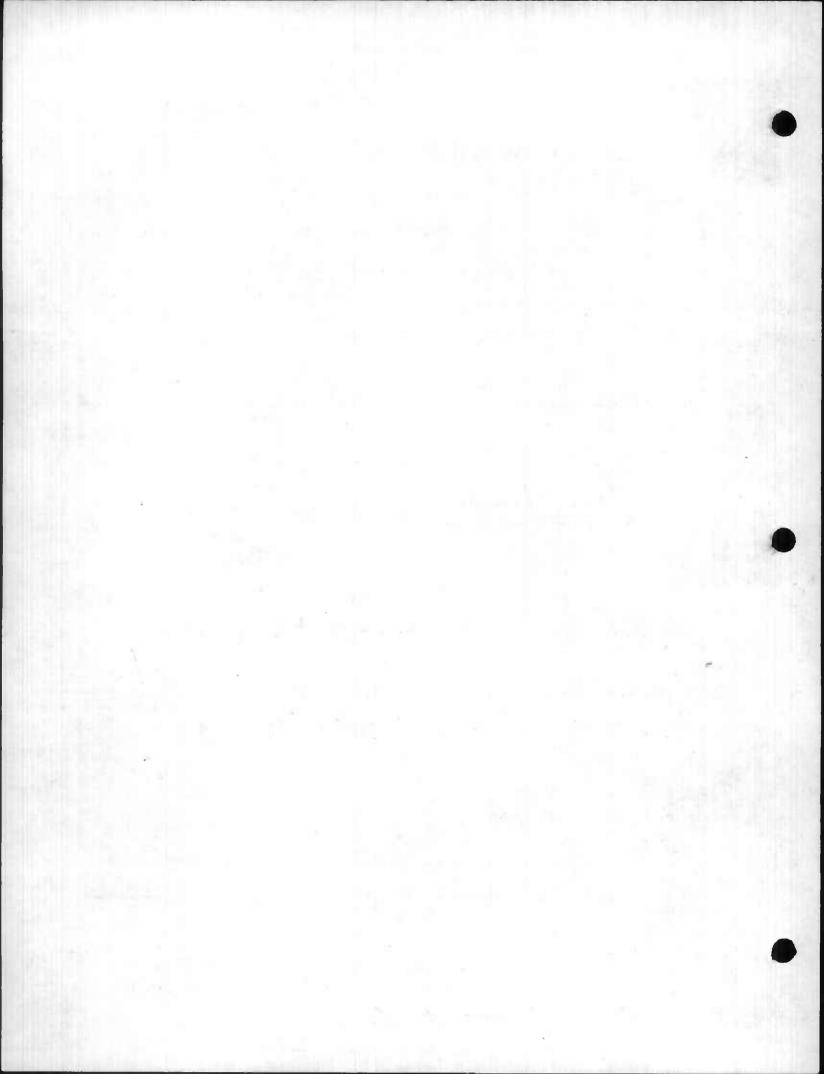
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29d. Data aigned (Month, Day, Year)

BKLAR MO 21014410 879.6574

MARCH 25 2000

DME



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth FORD Year **Physician** 10:11 AM TOA MARCH 12000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWard County General Hospital
5. Social Security Number 6. Sex 17. Age Illower last high deal Hillower HOWard Columbia If Under 1 Year Months Days If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Days Hours 577-30-2671 87 Director Jan. 1, 1913 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahona anoma MD Howard 1 ☐ Yes 2 No Columbia Director 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or hams 23s or must be 5404 Lightning View Road 21045 U.S.A. Funeral 13. Was Decadent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 Black 1 Yes 2 No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiere. Important: if them 27 is marked other than "namen any injury or other thanmals." 16b. Kind of Business/Industry University of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Cook College Park 6 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Oliver Turner Florence (unk) 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley Thomas (Daughter) 5404 Lightning View Road, Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Fort Lincoln 3/30/00 Bladensburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatum of Funeral Service Lice 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045 de 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical 24 Cm SHOUL Examiner Due to (or as a consequence of): Examine frestuls physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Round P.O. Box 68760, Lorbune Physician/Medical Due to (or as Diferent Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably M Unknown Dionto Division of Vital Records, à 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed page 2 i has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician:
within 24 hours after death.
To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2K No Certification: To 1 Properient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Detural 1 TYes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Morce 24, 200 0-34868 um mo 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Colubra, MA 2644 11055 LITTE Patrust 31. Date filed (Month, Day, Year) 32. Registrar's Signature

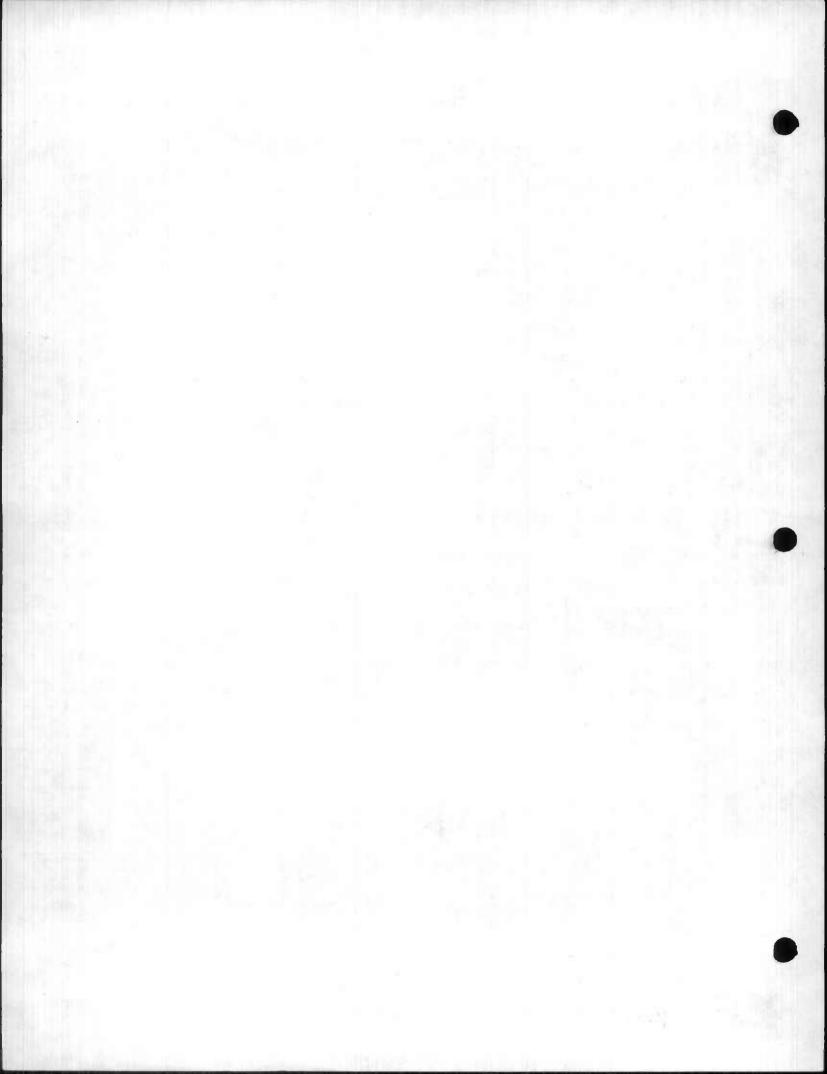
DHMH 16 Rev 6/95

State

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09958 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year FULLUM MARGARE MARCH 22, 2000 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death BALTIMORE NURSING HARBOR If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 10 M 20 F Hours 218-18-8225 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 4700 HARFORD 21214 RB 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Meritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12+4 HOME HOUSEWIFE NIA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN UNKNOWN 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARLO 1108, E. HOMBERG BAITS MD 21321 ELEANOR Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 3/24/2000 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 Donetion 5 Dother (Specify) ENTOMOMENT Cenatery OAKLAWN BALTO. ND 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility HARTLEY Miller Funeral Home CHTD. 23a. Pert 1. Erfler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. 7527 HARFORD RD. BAID MD 21234 Approximate Interval Between Onset and Death UROSEPSIS Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCULAR ACCIDENT Due to (or as a consequence of): NIMANY MALIGNANT HYPERTENSION Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No

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"natural", or items 23s or

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events.

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physician and the burial-transit Box 68760, USB P.O. should be det certificate this

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Records, Division of Vital Hospital or Attending 24 hours after death. Funeral Director: After Matter filled in by the fun To the

Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Completed 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Plesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suícide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

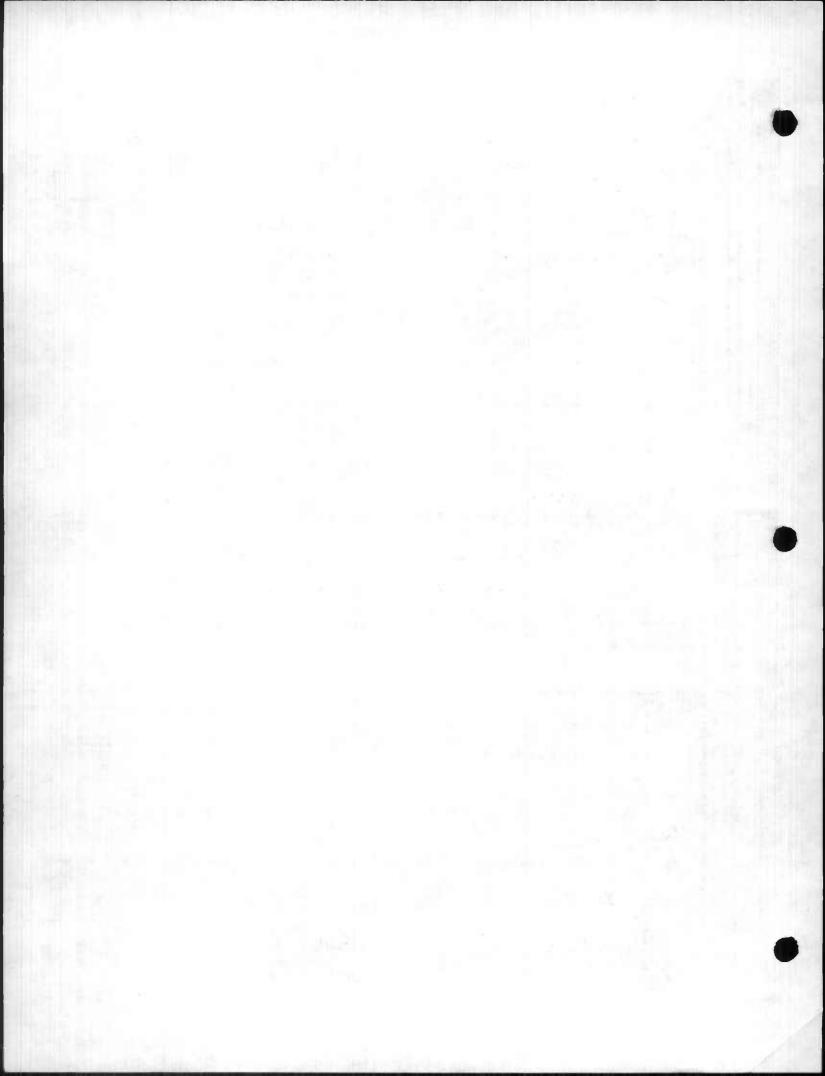
29b. Signature

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (flow 23a) (Type, Print)

INAI KEN IMPAGUATELLI. 1211. EATON STREET. BALTIMONE

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **JACK** FUTTERMAN MARCH 22, 2000 9:05 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE - GILCHRIST CENTER TOWSON BALTIMORE 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year 5. Social Security Number If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 219-42-6703 87 N.Y. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 Tho HOWARD ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8907 CHANTEL COURT 21043 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 M Yes 2 No NAVY
If Yes, Give
Year or Detes: WWTT 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced WHITE WWII 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 5+ SOCIAL SECURITY ADMIN. ASSISTANT COMMISSIONER 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) MAX **FUTTERMAN** YETTA BURBIL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL FUTTERMAN / NEPHEW 1623 THIRD AVENUE #34-K, NEW YORK, NY 10128 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 3/26/00 REISTERSTOWN, MD 21. Signature of Rineral Service Licenses Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AngioCAVCINOMA 12 months Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initisted events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 TYPE 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSAICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27, Menner of Desth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be axecuted Box 68760, P.O. Division of Vital Records. Attending Physician: **Physician**

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To the Hospital or Attend within 24 hours after deat To the Funeral Director: edical completely State

Registrar

29b. Signature and title of certifier ~ (en

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29c. License number 125205

1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

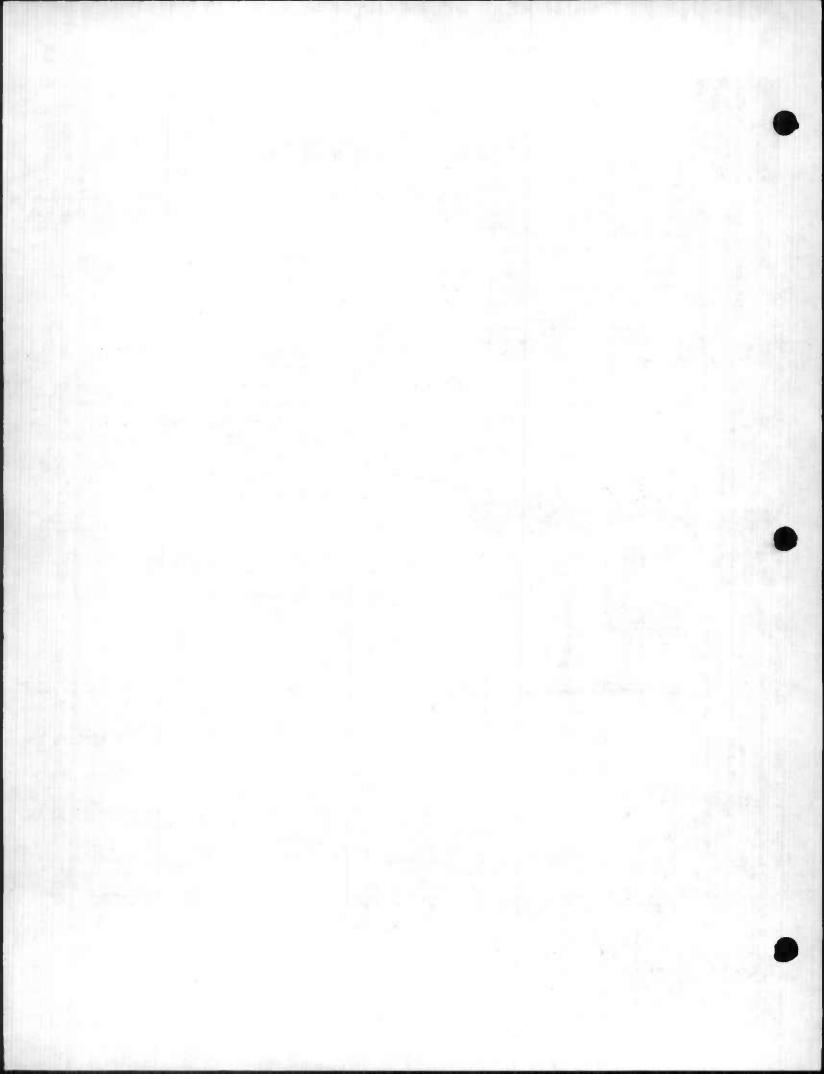
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Balto md Z1204 Riley 6BMC 6701 Charles W.A. 31. Date filed (Month, Day, Year)

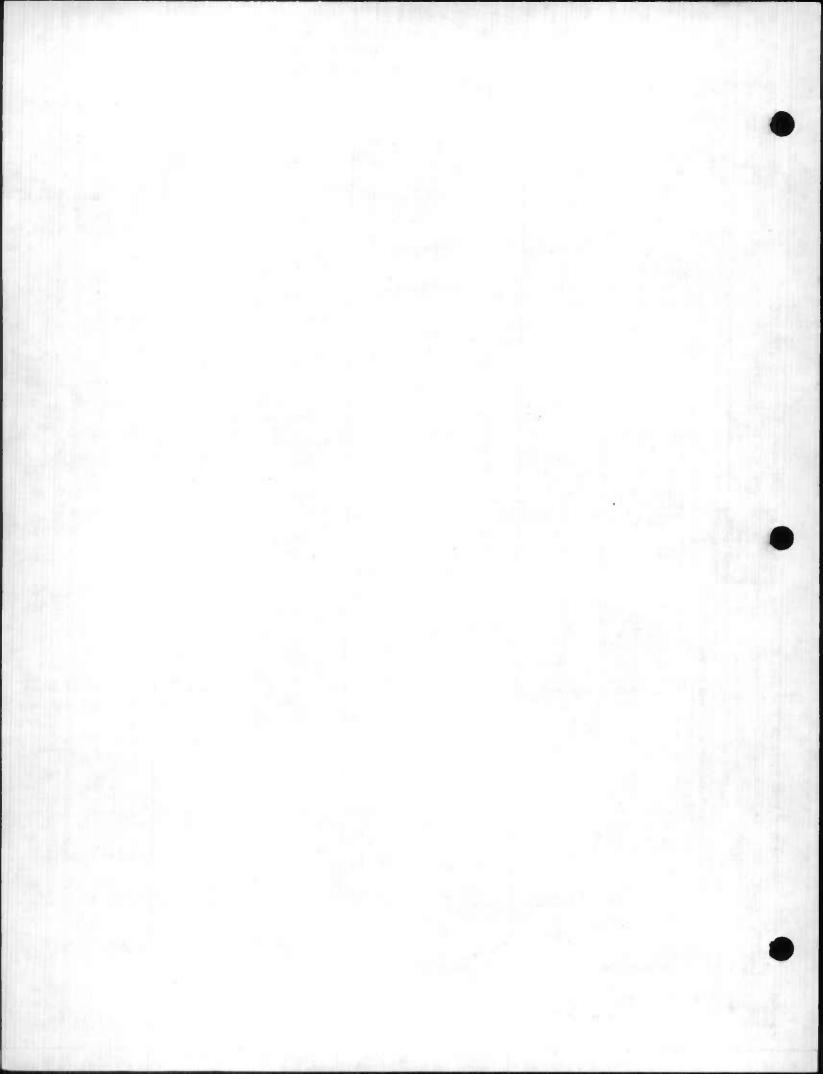
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32. Registrar's Signeture reneva



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician BECCA 6:31 pm E 00 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE BALT MARIS W 50 N 24 Hrs. 8. Dete E OW 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months -03-907710M 20XF Deys 220 Director 80 MD Usual Residence of Decedent the Maryland 10a. Stete 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Director BALTIMORE 1 ☐ Yes 2X No MD BALTIMORE 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Norra 23a 3203 OLD POST DRIVE #9 21208 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, Bleck, White, etc. hours after 1 Yes 2 No 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental is marked c **JACOB** GINSBERG BESSIE MIZRACH To 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra MARSHA WACHS / DAUGHTER 5 FIELDSTEAD COURT - OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Piece of Disposition (Neme of 20c. Location - City or Town, Stete cemetery, cremetory or other piece) 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) HEBREW YOUNG MEN CEMETERY 3/27/00 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signeture of 23a. Part1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, y heart feiture. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Intervel Between Onset and Death **Physician** MULTIPLE /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner the bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in deeth) Last pue Due to (or es e consequence of): 68760 Physician/Medical Due to (or es a consequence ol) 88 Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy lindings available prior to page 2 should Completed 24e. Wes an autopsy completion of cause of deeth? 1 Yes 2 0 No 1 ☐ Yes 2 ☐ No certificate of Vital Hospital or Attending Physician: director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Megner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division After 1 Netural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

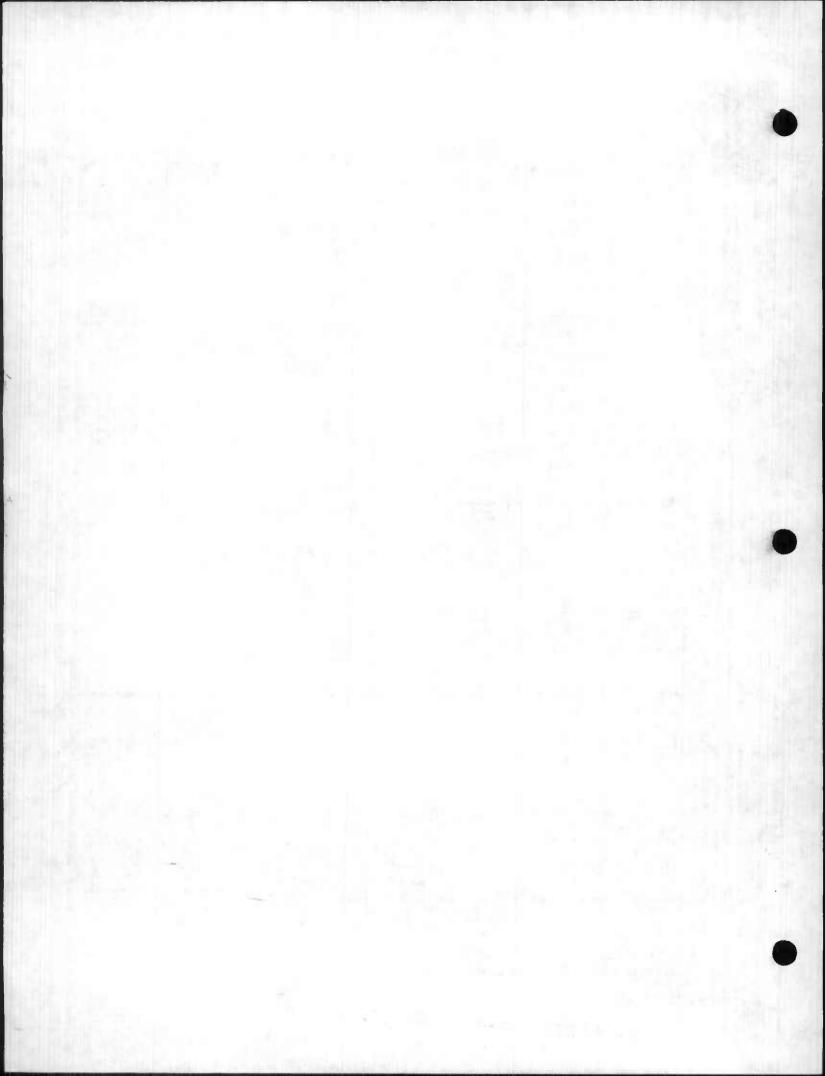
Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and menner steted. To the Hosp within 24 hou To the Funer completely fil 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43725 -00 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Christopher Ish, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State MAR 2 8 2000 Denewa Registrar



CORLISS VIOLA GRIMES

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	Reg. No.	961						
Physiciar	Decedent's Name (First, Middle, Last)			Time of Death						
/Medica	CORLISS VIOLA GRIMES		MARCH 25, 2000 1	2:57 AM						
Examine	4a Facility Name (If not Institution, give street and number) 4721 BELLE FORTE ROAD	4b. City, Town, or Local GARRISON	BALTIMORE							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last by 10 M 2 F 53	Yrs. If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Deta of Birth (Month, Day, Year) 9. Birthplace Country)	(State or Foreign						
Page 18		wn or Location	10d. ii	nside City Limits						
6 5 2 4	MD BALTIMORE GARRISON									
E 20 E	10e. Sireet and Number	10f. Zip Code	10g. Citizen of What Country?							
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urs after death value 234 Examiner must	3 ☐ Widowed 4 ☑ Divorced	13. Was Decedent of Hispanic Origin? (Specifit Pes, specify Cuban, Mexican, Puarto Ric	y Yes or No- lan, etc.) 14. Race - American In Black, White, etc. Specify BLACK	idian,						
72 hours hatural", fical Exa	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 TH GRADE VRS	Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry	у						
La Cara	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work dona during most of working life. DO NOT use ratired)	DA BURLLA CA	211001						
		PRINCIPAL 18 Mother's Name (6)	D.C. PUBLIC SC First, Middle, Maiden Sumama)	CHOOL						
The state of the s	LAJOIE GRIMES	HELEN U								
and Man		9b. Mailing Address (Street and Number or Rural F		(e)						
and 2 path a n 27 ts or tree	LAJOIE GRIMES, JR BROTHER 4	1721 BELLE FORT RD.	GARRISON , MD 212	208						
I tan	20a. Method of Disposition 20b. Place		Data 20c. Location - City or Town,	State						
emit. Pages 1. Apartment of He mportant: If Hen iny Injury or oth ISSB.	1 🗹 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify)	INCOLN CEMETERY 3-3	30-00 BRENTWOOD,	mo						
permit. Depart Importu	21. Signature of Funeral Service Licensee	22. Name and Address of Facility VAUGHN C. GREENE F	UNERAL SERVICE							
	23a Pert 1 Enta the death or complications that caused the death of	5151 BALTO. NATL' PIKE								
Physician	23a. Pent. Enter the damage or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or hearth and tist only one cause on each line. Approximate thiaval Batween Onset and Death									
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he law requires that e has been signed to age 2 should be dete			24e. Was an autopsy performed? 24b. Ware a availab	utopsy findings						
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The law ate has page 2			1 Yas 2 No 1 Ya	8 20 No						
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Physician: this certificant director.	YN Yas 2 No Hospitat: 1 Innatient 2 FR/		5XResidence 6 □Other (Specify)							
	27. Manner of Death 1 Natural 28e. Data of Injury (Month, Day Year) 28b 27 Accident invastigation		d. Dascribe how injury occurred from the think							
f or Attending after death. Director: After din by the fune	3 Suicide 6 Could not be datarmined 28e. Place of Injury - Al home, building, etc. (Specify)		Location (Street and Number or Rural Ro City or Town, Stata) 47-21 Belle	on (Street and Number or Rural Route Number, r Town, Stata) 4721 Belle fut Rural						
To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the			due to the cause(s) and mannar as stated	i.						
within To the comple	29b. Signatura and little of certifier	29c. Licansa number	29d. Data signed (Month, Day,							
	Theodow Mich ma	O.C.M.E	MARCH 25, 2	000						
()	30. Name and address of person who completed cause of death (Item 23a	(Type, Print) Penn Street, Baltimore	e, Maryland 21201	10 115						
State	21 Date Illed (Month Day Year) 20 Presidente Signature		_							
Registra		9. sparks								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 846 pm reene 2000 Son 26, /Medical 4e. Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner General Maryland Hospital Baltimore 8. Dete of Birth (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Country) State or Foreign Months Deys 226-30-688 Usuel Residence of Decedent 1 M 2□ F Hours Director 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Maryland Director 1 XYes 2 No mor 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò Herns 23a 21 Funeral d Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. 14. Race -American Indlen, Bleck, White, etc. 1 Never Married 2 Married 1 XYes 2 □ No If Yes, Give Baltimore, Maryland 21215-0020 "natural", or 1□ Yes 2 No Specify: by 3 Widowed 4 □ Divorced Yeer or Detes: Hmerican 95 Can Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumetic event, the Meany Injury or other traumetic event. Elementary/Secondary (0-12) College (1-4or 5+) endeni 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be appison Pages 1 and 2 should be nent of Health and Mental greene 2 nnsor Informent's Name/Relationship (Type, Print) (Brother) 19b. Meiling Address (Street and Number or Burel Route Number, City or Town. Zip Code Md. 21230 2604 Tre 101 To 20b. Plece of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State cometery crematory or other place) 2000 butus 22. Name end Address of Facility
Toseph L. Ru 21. Sign bye of Funeral Service Aicenses Joseph 2222 ral tome une North Md. 21216 Ave. W. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, i.j. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequenca of) Records, P.O. Box 68760 physician The law requires that the death certificate be Physician/Medical the Due to (or es e consequença of): use as attending | signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No p 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? peed has page 2 2 12 No cartificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartific 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 3 DOA 2 ☐ ER/Outpetient 28e. Dete of Injury (Month, Dey Yeer) funeral 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending Investigation 2 No 1 Yes 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) in by 4 Homicide 10 titying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner es steted.

Widical Examiner: On the bests of examination and/or investigation in my existence de the course of the ceuse(s) and menner es steted. Medical 29a. Certifier pletely dical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29b. Signatur 29d. Date shoed (Mynth, Dey, Year) 29c. License number 00 end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

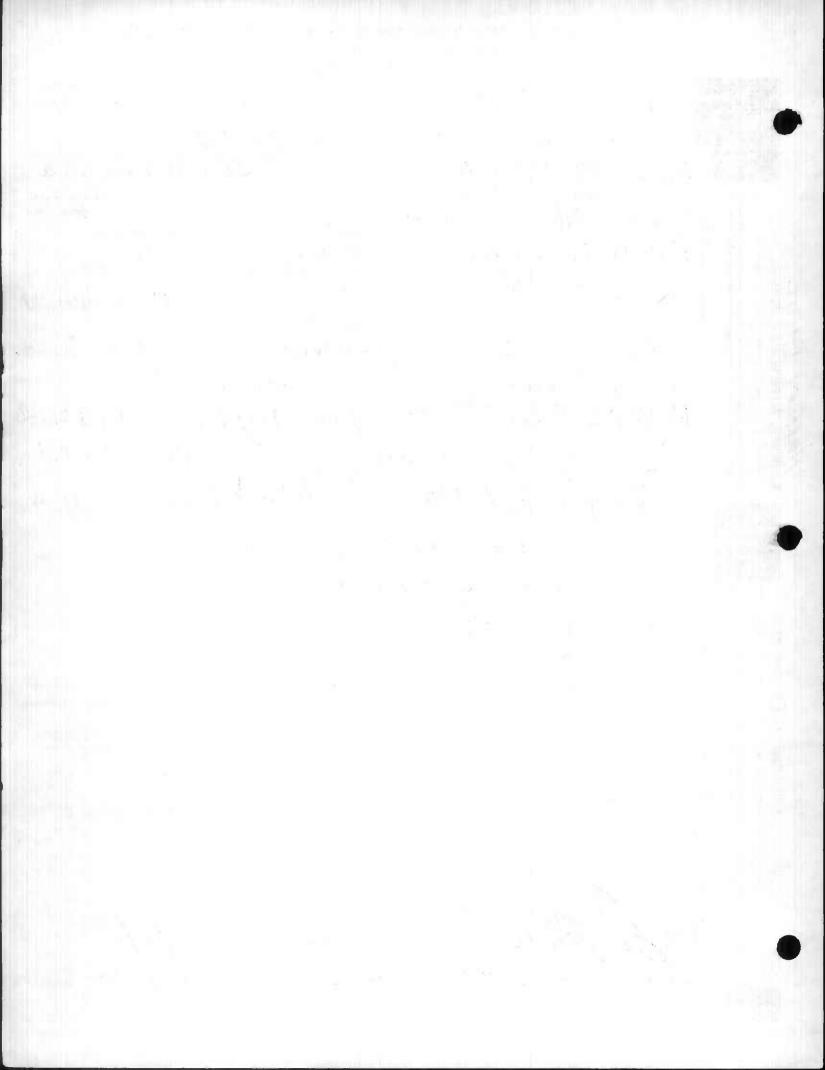
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32. Registrar's Signature

State Registrar Jarcalus,

31. Dete filed (MARPa 2 78") 2000

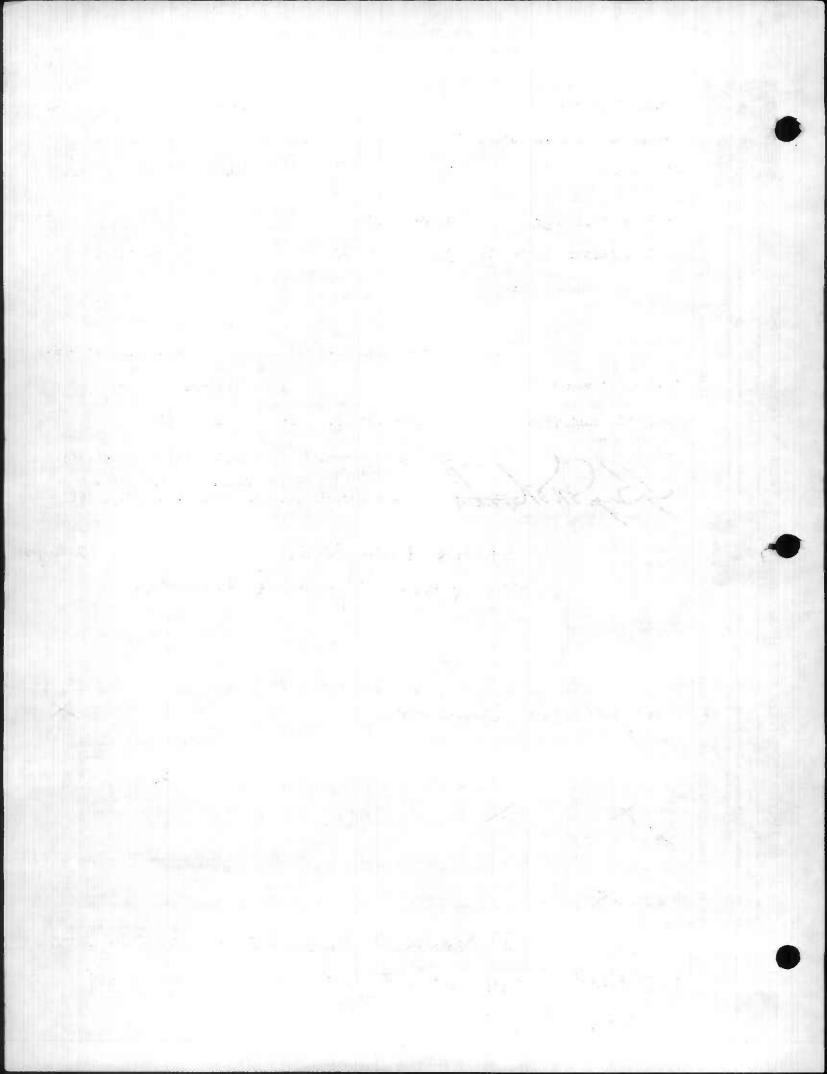


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 23, 2000 Sam Glovinsky March 5 PM. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Montgomery General Hospital Olney, Montgomery If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Dey, Year) March 29,1921 9. Birthplaca (Stata or Foreign Country) New York 7. Aga (In yrs. last birthday) **Funeral** 110 M 2□ F Hours Min 065-12-3547 78 Yrs. Director Usual Residence of Deceden the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itsma 23s or 28s-f show traumatic avent, the Medical Example; must be notified at 1 ☐ Yes > No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 3330 N. Leisure World Blvd. #504 20906 United States deeth Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1∑∑Yas 2 □ No It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. pernit. Peges 1 end 2 should be filed within 72 hours after Department of Health end Mental Hygiene. Important: If Item 27 fa marked other than "natural", or Ital 1 Navar Married 2 XMarried Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade complated) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Administrative Officer Department of Navy. 3 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Lest) Phillip Glovinsky Sadie Glovinsky 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sandy Glovinsky/Son 5904 Oslo Ct. Columbia, MD. other 20a. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Burial 2 Cremation any Injury or o 3 DBemoval from State King David Memorial 3/26/00 Falls Church, VA. 21. Signature d 22. Name and Address of Facility Takoma Funeral Home. 254 Carroll St. NW. Washington, DC. 20012 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting In daath) 12 days Examiner Myocardial Examiner physician and is the burief-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): 88 - BSI jo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Onknown signed by by 2 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy been completion of cause of death? hes 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) 1 ☐ Yes 1 Impatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 28d. Dascribe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Vatural 5 Pending 1 Yes 2 No deeth. 2 Accident investigation To the Hospital or Attandithin 24 hours after deet To the Funeral Director: 6 ☐ Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyeictan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier D45285 March 23, 2000 30. Name and address of person who completed cause of death (Item 23a) (Typa, Print) Blvd, #113, Silver spring, University 31. Date tiled (Month, Dey, Year) 32. Registrar's Signature

Registrar

MAR 2 8 2000

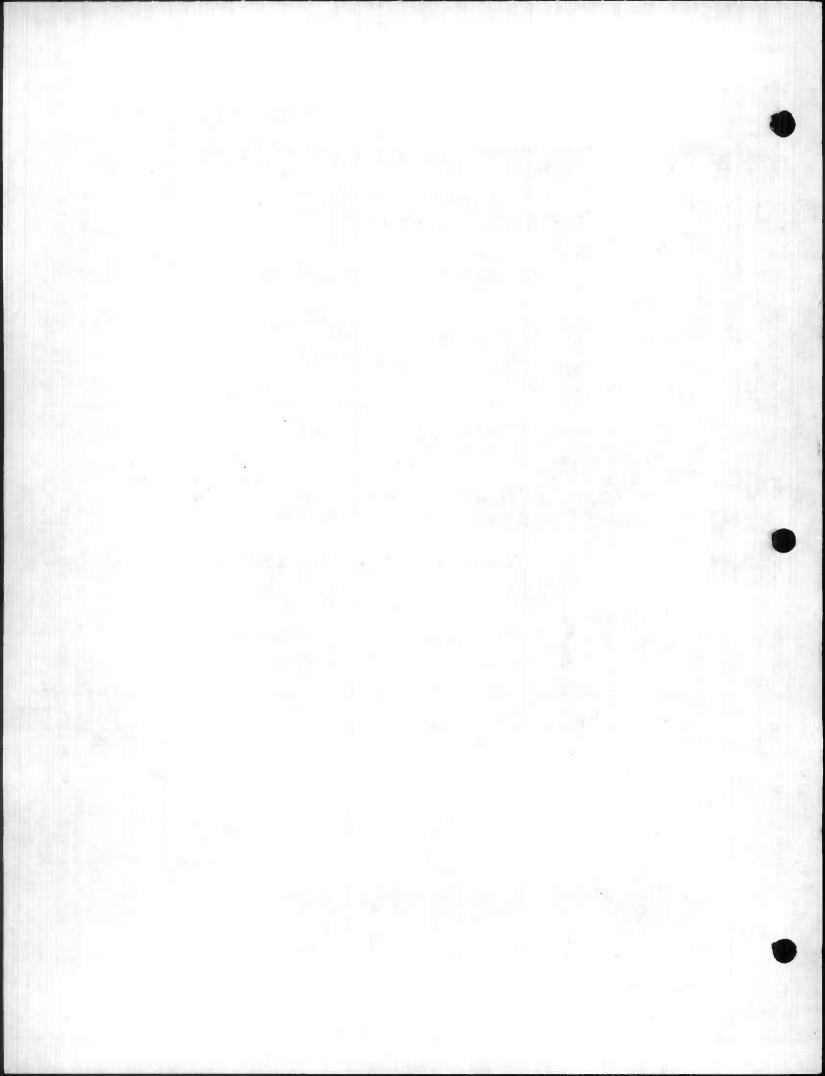


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9964 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Physician Month March 25 0535 DOW /Medical 4a Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Baltimore Center Charlostown OVE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** Months Days 165-07-4420 10 M 20 F 89 Yrs Jan. 15,1911 Pennsylvania Director Usual Residence of Decedant 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 ☐ Yas 2 N No Director Catonsville 'natural', or harms 23s or 28s-f 10e. Street and Number 10f Zin Code 10a, Citizen of What Country? 707 Maiden Choice Lane Apt 3406 21228 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 █No If Yas, Giva 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Personal Administrator Federal Government 18. Mother's Name (First, Middle, Meiden Sumema) 17. Fathar's Nama (First, Middla, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I important: If Item 27 is marked of William J. Delaney Helen (Carroll) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Walter E. Boek (Personal Rep) 5011 Lowell St., N.W., Washington D.C. 20016 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Surial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) New Cathedral Cemetery 3/27/00 Baltimore, Maryland 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 21. Signatura of Funaral Sarvice Licensee 1019 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disaases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) . Atheroscleratic artery Examiner Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 □ Yes 2 □ No Atrial fibrillation of Vital Records, P P 24b. Wara autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? Congestive Heart Failure 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Other: Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Netural 5 Panding invastigation 1 Yes 2 No 2 Accidant 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) after A 4 Homicide hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier To the Hor within 24 h To the Fur completely 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) D 30989 2005 30. Nama end eddrass of person who completed causa of death (Item 23a) (Type, Print) Maiden Choice in cotoneville Myla M Cour 31. Date tiled (Month, Day, Year) MD 111 M Corporter

Registrar DHMH 16 Rev 6/95

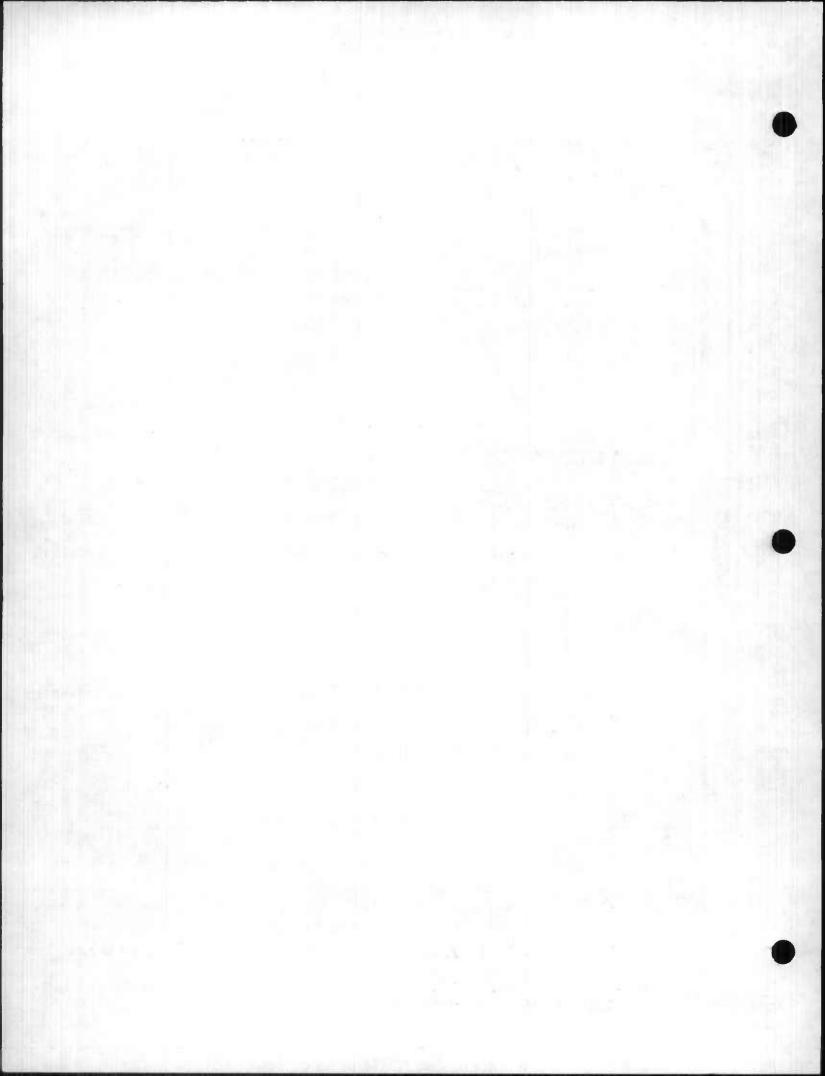
State

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

			Certif	ficate of	Death	R	g. No.	1 099	63	
Dharistan	1. Decedent's Name (First, Middle, La	st)	71,5				h Day	3. Tirr	e of Death	
Physician /Medical	JEAN F. GO	UGH							700 09:15 AN	
Examiner	4a Facility Neme (If not institution, give				4b. City, Town, or I	ocation of Death	4c. County	of Death		
	Saint Joseph			Under 1 Year	Tows			Baltimo		
Funeral Director	5. Social Security Number 6. S 2 1 4 - 2 4 - 3085	7. Age (In yrs.		lonths Days	Hours Min.	8. Date of Birth (Month, Day, 03/08/	1929	9. Birthplece (Sta Country) MARYLAN		
7 Bu	10a. State 10b. County	10c. Ci	ty, Town or Locati	on				10d. Insid	le City Limits	
or 28e-f show be notified at Director	MD BALTIM	ORE		WSON					Yes 2 No	
	3 SKIDMORE COU	1204	10g. Citizen of Whet Country? USA							
hours after death v turnif, or thems 23a at Examiner must ad by Funeral	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:		Decedent of es, specify Cut Yes 2 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		e - American India ck, White, etc. WHITE	n,	
다 문화 학	15. Decedent's Ed (Specify only highest gra		16a. Decedent	's Usual Occu	pation during most of wor	kina	16b. Kind of Bu	usiness/Industry	1-14	
within the Man	Elementary/Secondary (0-12) 12YRS	College (1-4or 5+)		NOT use retire EWIFE	during most of world)		номв	EMAKER		
d other d other svent, is	17. Fether's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	Aaiden Suman	10)		
Menta Menta To T	WILLIAM HERMA	N FROME, JR.			MARY I	ELIZABE'	TH WAF	SD		
and and	19a. Intormant's Neme/Relationship (t and Number or Ru					
m 27 her tr	THOMAS W. GOUG				RE CT. 7			204.		
ent: If lie ury or of	20a. Method of Disposition 1 □ Buriel 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Disposition cometery, cremate EEN MOU	ory or other ple	EMATORY			City or Town, Stat		
Departiment any inj ang in	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.									
	23a. Part1. Enter the disease, or company shock, or heart teilure. List only	plications that caused the dee						Approx	imate Between	
hysician									and Deeth	
Medical xaminer	Immediate Couse (Finat diseasa or condition resulting in death)	METASTAT I	C ADEN	DCARCI	NOMA OF	THE LL	JNG	MO	NTHS	
 5		Due to (or as a consequer	nce of):						
in and fal-transit Examiner	Commented to the second	b. — Due to (or as a consequence of):								
	Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury									
physicis ts the bu	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (c	or es e consequen	ce of):						
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d by the attending etached for use a Physician/M	Part II. Other significant conditions of	iven in Part I.			ntribute to the cau					
2 2	DIABETES MELLI	ITUS				1 🗆 Yı	2 No	3 Probably	4 ☐ Unknown	
sate has been significant to page 2 should to Completed 1	CHRONIC OBSTRUCTIVE PULMONARY DISEASE					performed? available complet		24b. Were autopavailable p completion of death?	rior to	
Dage om						1 🗆 Ye	s 20 No	1 ☐ Yes	20 No	
certificate rector, pag	25. Was case reterred to medical				26. Placa of Dea	th (Check only on	/\		1	
this certain direction.	examiner?	Hospital: 10 Inpatient 2	ER/Outpatient	3 DOA O	her:	ome 5 ☐ Reside		er (Specify)	. 19.4	
After th funeral	27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry et ork?	28d. Describe ho	w injury occur	red	1	
deat to:	2 Accident investigation 3 Sulcide 6 Could not be determined	M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Number,			Number,		
hours after death. Ineral Director: After ity filled in by the fune cal Certification		curred at the 6	City or Town, State) urred et the time, date and place, and due to the cause(s) end manner as stated.							
Medical C	one) Zi Medicat Exam	niner: On the basis of examine and menner stated.	otion and/or invest	igation, in my	opinion, deeth occu	rred at the time, da	ate and placa,	and due to the ceu		
W W	29b. Signature end title of certifier	1 1/ 1			se number	2	29d. Date signed (Month, Day, Year)			
> 1	naturida	of D. de Le	on	D19	9508		3/2	1/2000	0	
V	30. Name and eddress of person who o		m 23a) (Type, Prir				1 1			
		DELEON, M.D.		OSLER	R DRIVE,	TOWSON	, MAR	ALUND 5	1204	
State	31. Date tiled (Month, Mar Res 8	2000 32. Regularar's Signa	D.	100	Kh/					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MELIMOR GOMZALES MARCH 2000 4c. County of Death 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE & Hours | Min. | 8. Date of Birth (Month, Day, Year) BALTIMORE SAMBRITAN Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) D 5. Social Security Number 10 M 20 F 212-26-101 March 20, 192 Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No BALTIMORE 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? E. BELVEDERE 21239 1601 U.S.A AUE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (DNo If Yes, Give Year or Dates; 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 DWidowed 4 □ Divorced WhiTe 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service, Rep WesTERN Union NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) CLEMENT HARTSELL Kimmons GERTIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) HARFORD VIEW DR. BATTO. MD BONNIE. L. HIGGINS 9222 21234 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 3/23/2000 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BATTO. MD 4 ☐ Donation 5 ☐ Other (Specify) Greenmount cometery HARTLEY Miller Funeral Home CATD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LEMORRHAGIC CEKEBROUASCHLAR ACGORYT Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown HYPER TEMSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy DIALETES 1 ☐ Yes

Physician /Medical Examiner

eup

The law requires that the death certificets be assecuted

Box 68760,

Records, P.O.

Division of Vital

Physicien:

Attanding death.

To the Hospital or Attandamin 24 hours after deal To the Funeral Director:

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Physician

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permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental hygiens. Important: If from 27 is marked other than "natural" and plage.

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Completed 8

1 ☐ Yes 2 No

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No Hospitat: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27 Magner of Death 28c. tnjury at Work? 28d. Describe how injury occurred 10X Natural
2 Accident 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certified 29c. License number

MARCH 22, 2000

29d. Date signed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print)

RAPITAGL De0 00 LOCH RAVEN BLUD BALTIMORE MD 21239 5601 31. Date filed (Month, Day, Year)

State Registrar

Certification: To

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MAR 2 8 2000

32 Registrar'a Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth MARCH 9, 2000 4:00 A.M. 4b. City, Town, or Location of Deeth 4c. County of Deeth TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Months Deys Hours MD

1. Decedent's Neme (First, Middle, Last) **Physician** THOMAS A . GRAY /Medical 4e Fecility Neme (If not Institution, give street end number) Examiner MANOR CARE HEALTH 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** 1 M 2□ F Yrs 218-26-8685 Dec 10, 1930 Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location ?? is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be northed at MD Baltimore Towson Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21286 USA #1506 305 E. Joppa Road Funeral death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. should be filed within 72 hours after and Mental Hygiene. 1 X Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 2 US Postal Service Post Office Mgr 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 10 Watson W. Gray Dorothy Davis 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ernit. Pages 1 and 2 st genmant of Health and montant: If Nem 27 is n Mary Johnston/niece 5826 Tennessee Ave Clarendon Hills, IL 60514 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete ò 4 X Donetion 5 ☐ Other (Specify) 21. Signature of Europh Service Licensee Ade Director ²² Name end Address of Fecility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examina Examiner certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequênce of) the buriel-tran Physician/Medical Due to (or es e consequence of) as i 980 Division of Vital Records, P.O. the a detached

Pert II. Other elantificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably SUnknown

24e. Wes en eutopsy

24b. Were autopsy tindings avellable prior to completion of ceuse of deeth?

Approximate Intervel Between Onset end Deeth

10d. Inside City Limits

white

1 Yes 2 No

1 Yes 2 No

1 Yes 2 No

25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 474 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

12 Sectifying Invector: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler: On the basis of examination and log investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

(Check only one) 2 Medical Fun er: On the basis of exeminetion end marmer stated. 29b. Signeture end title of co

29d. Dete signed (Month, Dey, Year)

30. Name end eddress of pers pleted ceuse of doe (Type Print) 7600 Oscer

State Registrar 31. Date filed (Month, Dey, Year) MAR 2 8 2000

32. Registrer's Signeture

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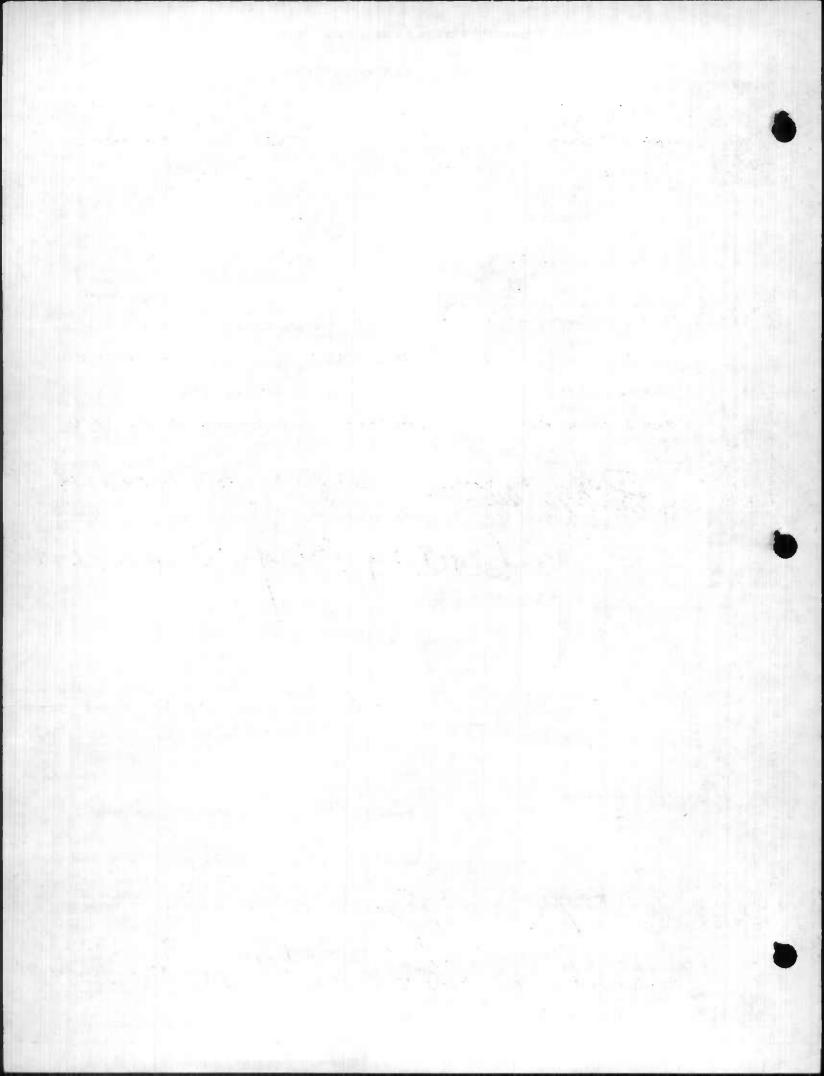
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10

Certification:

Medical

4 Homicide



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yea GIETCZA Lita 7:23 pm March 23 2000 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street end number) 4c. County of Death JOHNS

5. Social Security Number 8. Date of Birth (Month, Day, Year) PKINS HUSPITAL If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 1□M 2以F 76 218 18 2795 July 20 1923 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Ves 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 U.S.A. 513 S. Wolfe St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Merried 2 ☐ Merried 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Murawska James Gierczak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 60 Bosun Way Beach, Florida 33483 Bernard J. Herdock/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 KBurial 2 Cremetion 3 Removel from State March 27 2000 Holy Rosary Cemetery Baltimore Co., MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Lilly & Zeiler, Inc. Funeral Home ler 1901 Eastern Ave., Baltimore, MD 21231 23a. Part1. Enter the disease, or complications that current the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel ain diseese or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 MUnknown ension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 225No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760

The law requires that the death certificate be executed signed by the attending be detached for use Division of Vital Records, P.O. certificate or Attending Physician: funeral director, this After death. 24 hours after deat Funeral Director: in by Hospital

Physician

/Medical

Examiner

Funeral

Director

w 23s or 21s-f show must be notified at

or items

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Hygiene.

Department of Health a Important: if Item 27 is any injury or other trau

Physician /Medical

Examiner

pug the burial-tran

45 45

Physician/Medical

Be Completed by

Medical Certification: To

29e. Certifier

(Check only one)

haleb

altimore, Maryland 21215-0020

Director

Funeral

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Registrar

31. Date filed (Month, Day, Year) MAR 2 8 2000

29b. Signeture and title of certifier

rohas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600

North 32. Registrar's Signature

MD

Wolle

000

Street Baltimore

March

29d, Date signed (Month, Day, Year)

23

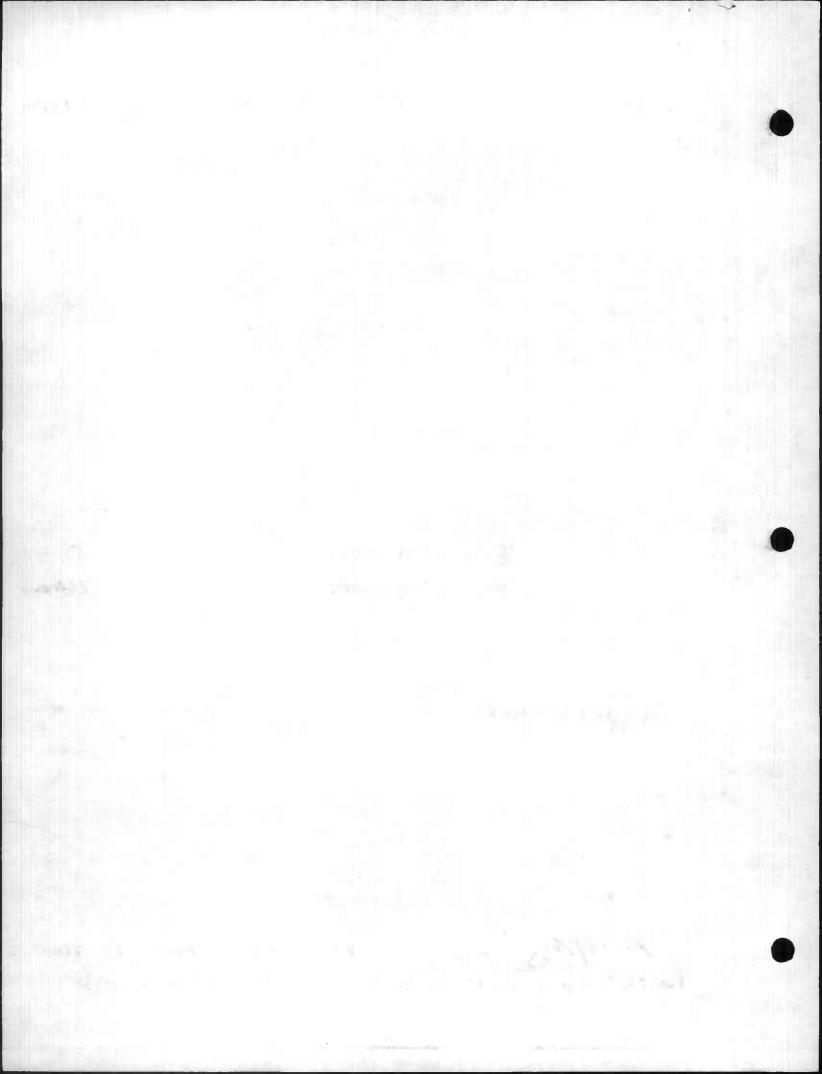
2000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted.

KES

29c. License number



If Under 1 Year

Days

Months

If Under 24 Hrs.

26

10

Hours

Birthplaca (State or Foreign Country)

21215

29d. Date signed (Month, Dey, Year) /18/00.

Approximete Intervel Between Onset and Death

10d. Inside City Limits 1X Yes 2 No

M.D

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 800 III March ,2000 William Howard Watson 4a Facility Name (If not institution, give street and number) 4b-City, Town, or Location of Death 4c. County of Death Copy baltimore

7. Age (In vis. last birthday)

45

Physician
/Medical
Examiner

lary lano

214-64-0134

Usual Residence of Decedent

5. Social Security Number

reneral

11XM 2□ F

6. Sex

Funeral Director

death with the Maryland r 28a-f ahow TR 23a or or herns 23s Hygiene.

Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If Hem 27 is marked other altimore, Physician

1/1/iam

/Medical Examiner

physicien and the burial-transit The lew requires that the death certificate be executed US0 23 signed by the at d be detached for has funeral director, 110 After

Box 68760, P.O. Division of Vital Records, or Attending Physician: To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. edical

10e. State 10b. County 10c. City. Town or Location Funeral Director MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 924 Chauncey Ave 21217 U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1¥ Yes 2 No If Yes, Give 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12th grade Disabled Disabled 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 8 William H. Watson Jr. Rose Lee Midders 19a. Informent's Neme/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 Chauncey Ave, Baltimore Md Michele D. Watson-Wife 21217 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Qurial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 3-27-00 Owings Mills, Md Garrison Forest Vet 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave. Baltimore Md enter the mode of dying, such as cardiac or respiretory errest. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each tine. 100 volemic Immediate Cause (Fine) disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings available prior to Completed 24a. Wes en autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 DNaturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1(I) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

DHMH 16 Rev 6/95

State Registrar (Check only one)

29b. Signeture and title of certifier

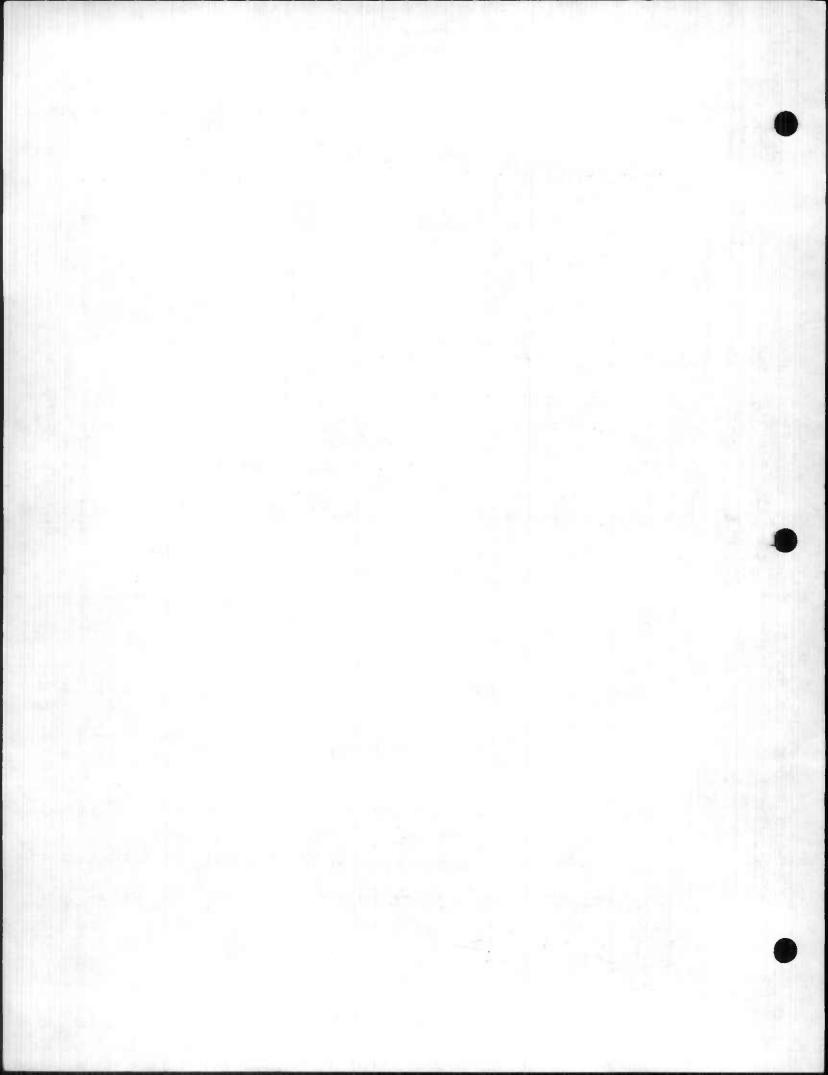
38. Name and address of person who comple

em 23a) (Type, Print)

32. Registrar's Signature

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and menner steted.

29c. License number



amend item 23a, b, 27 per me G781 3/29/00 yg Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. WILLIAM E. HARRIS State of Maryland / Department of Health and Mental Hygiene 00-1624-510 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year Physician Harris Sr. William Earl 1412 PM 21 2000 MARCH /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MERCY HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months XXX 2DF Yrs. Director 219-34-1231 60 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or hams 23s or 28s-f show the Medical Exercises must be notified at 1 Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.

14. Race - American Indian, Funeral 5312 Lynview 21215 Ave 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 2 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ified within 7 Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) Yellow Cab Company Cab Driver 12th_grade na 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pennii. Pages 1 and 2 should be file Department of Health and Mental Hy Important if flam 27 is marked oth any Injury or other traumatic event Be Walter C. Harris Sr. Olivia Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3401 Menlo Drive, Baltimore Md 21215 Generrio K. Harris-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 □ Other (Specify) Crownsville Vet. Cem. 3-27-00 Crownsville, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 10 23. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Baltimore Md 21215 Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final . CARDIAC ARRHYTHMIA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine HYPERIENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE physician and the burial-transit that the death certificets be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) 980 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed page 2 s 2 No Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yes 2□ No Certification: To 1 Inpetient XXER/Outpetient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 ⊠Natural 2 ☐ Accident or Attending 5 Pending after death. Director: Aft 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in the edical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of corps 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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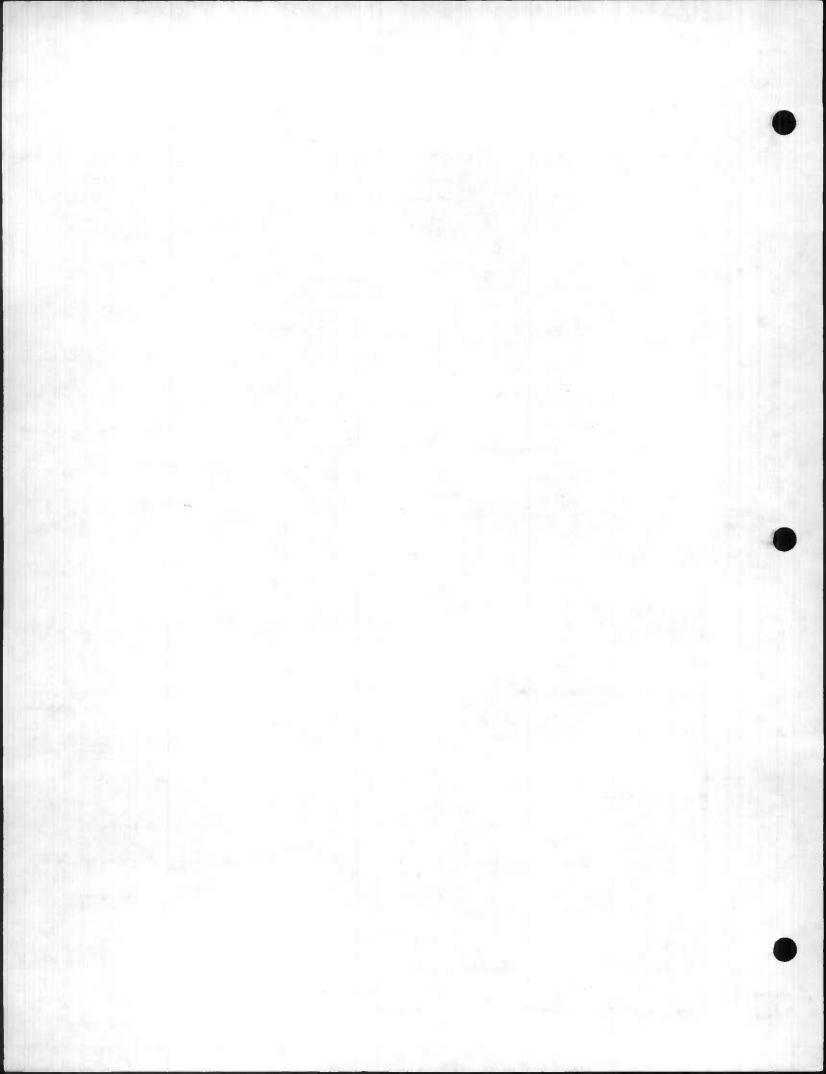
31. Date filed (Month, Day, Year)

30. Name and address of pursual who completed cause of death (Item 23a) (Type, Print) JACK M. TIMS, M.D. 111

Penn Street, Baltimore, Maryland 21201 32. Registres Signature

OCME

MARCH 22, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ASP AMEND ITEMS: #23 PART I, 27, 28A-F PER MEDELLICATE OF Death 1. Decedent's Nama (First, Middle, Last) 2 Data of Death 3 Time of Death Month **Physician** 25 2000 Edwin House MARCH 3:26 A /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner 5252 W. ST. CHARLES AVE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1XM 2□ F Yrs. Director 219-50-3527 Usual Residence of Decedent 49 06 06 M.D the Maryland r 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 17 Yas 2 No Director MD NA Baltimore 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code than "naturel", or items 23s or the Medical Exercises must be Funeral 5252 St. Charles 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 21215 Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) TX as 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: 2 3 Widowad 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Cicurular al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Distribution Adveristing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental P 1e marked of Ajay House Gladys Bristow 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ie n any Injury or other treun Nataki S. Johnson-Daughter 1226 Euclid St. N.W., Washington D.C. 20009 20c. Location - City or Town, Stata 20a. Method of Disposition Date

21. Signature of Funeral Service Licensee

1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify)

Physician /Medical Examiner

68760

Box

P.O.

Records.

of Vital

Division

Amending

To the Hospital o within 24 hours af To the Funeral DI

siclan and bunial-transit ed by the attending physician detached for use as the buna Physician/Medical SI signed by à 2 should be Completed has page Be 10 Certification: After death. after death Director: / d in by the f

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23a. Part1. Enter the disease, or complications that causad the death. th. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disaase or condition resulting in death) NARCOTIC INTOXICATION Due to (or as a consequence of): Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or as a consequence of): thet initiated events resulting in death) Last Dua to (or as a consequence of):

Metro

II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed'

March F/H West

1 yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) XYes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of A 28a. Dete of Injury (Month, Day Year) FOUND: 3-25-00 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation FOUND: M 1 Neturet 1 Yes 2 No UNKNOWN 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 5 2 5 2 ST . CHARLES

3 Suicide 6 X Could not be 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)
RESIDENCE 4 Homicide

BALTIMORE, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the fime, date and placa, and due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. Licansa number

O.C.M.E

wo 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Milyma

111 Penn Street, Baltimore, Maryland 21201

Crematory Inc. 3/27/00 Baltimore, Md 22. Name and Address of Facility

State Registrar

DHMH 16 Rev 6/95

illed in by

MAR 2 8 2000

29b. Signature and title of certifian

32. Registrar's Signature Sports

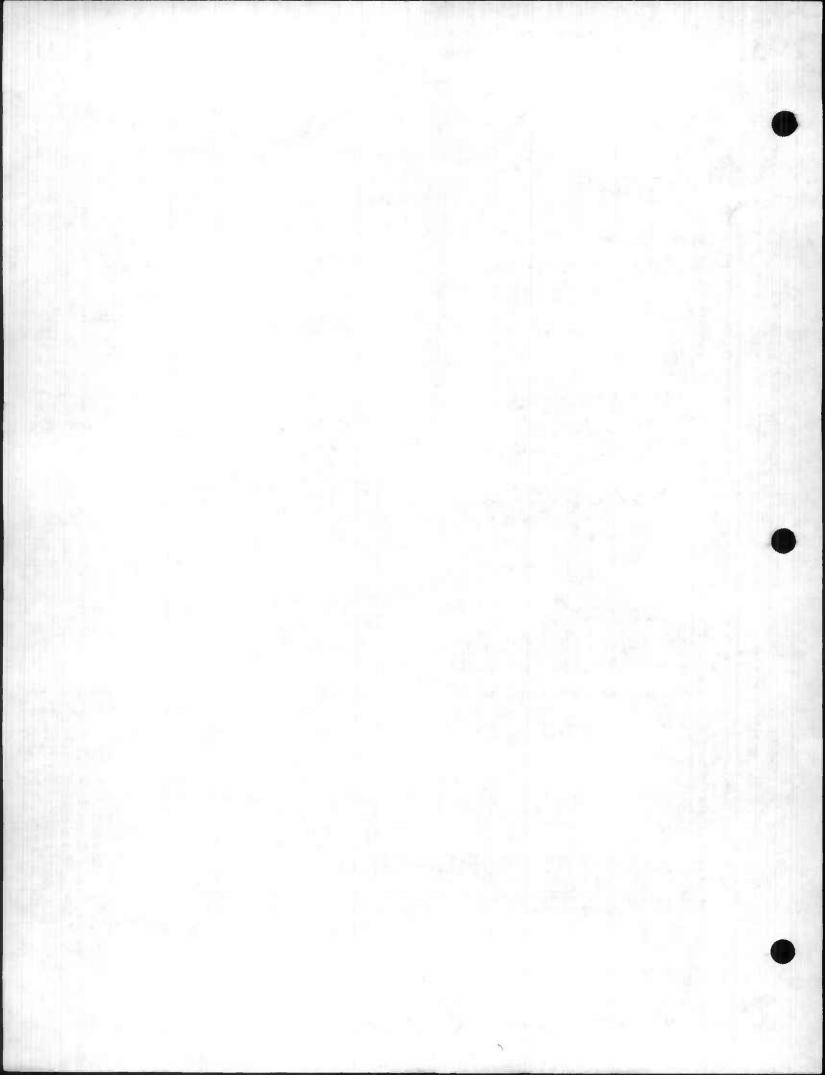
ORIGINAL

29d. Data signad (Month, Day, Year) MARCH 25,2000

Interval Between Onset and Death

31. Date filed (Month, Day, Year)

edical



Please 1	Type or Print in B					
	State of Maryland	d / Department of Certificate of		, ,	ene	09972
1. Decedent's Neme (First, Middle, Las	- // .11	one		2. Deta of Death Month MARCH 22	Day Year	3. Time of Death 7:05 P.M.
4e Facility Neme (If not institution, give VAMHCS FORT HOWARI			4b. City, Town, or Lo	ocation of Death	4c. County of Dee	
5. Social Security Number 6. Sa 426–18–3705 Usuel Residence of Decedent	ax 7. Age (In yrs. It	dest birthdey) If Under 1 Yaa Months Days	ar If Undar 24 Hrs.	8. Dete of Birth (Month, Day, Y		hhplace (State or Foreign puntry)
10a. State 10b. County Maryland Bay	timore 100. City	y, Town or Location PiK	lesville			10d. Inside City Limits 1 Ves 2 No
10e. Street and Number \$118 Arrowh	ead Rd.	10f. Zlp Code	21208		. Citizen of What Co	4
11. Meritel Stetua 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. Was Decedent Evar in U,S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Yeer or Detes:	S. 13. Wes Decedent of If Yes, specify Cu	f Hispanic Origin? (Spuber, Mexicen, Puerto o Specify:	ecify Yas or No- Rican, etc.)	14. Race - Ame Bleck, Whit	
15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+) Hawtherne	16a. Decedent's Usuel Occi (Give kind of work don life. DO NOT use retir Machine (ne during most of working)	e (First, Middle, Ma	b. Kind of Business The Manager of Sumerical Summers of Sumerical	Tire Co.
19a. Informant's Name/Relationship (T		19b. Meiling Address (Street	Nheud Pa	al Route Number, C	City or Town, State,	Zip Code) . Z.1 Z.4)8
20e. Method of Disposition 1 Burial 2 Cramation 3 1 4 Donetion 5 Other (Specify,	Removel from Stete	lece of Disposition (Name of emetery, cremetory or other pi	Vet, Cen	Dete 20 3/29 7	c. Location - City or Pikesvill-	Town, Stela
21. Signature of Funeral Sarvice Licens	Parker	22. Name end Add 3512 Free	lress of Facility Kev derick A	ve. BN	timore A	D. 21229
23e. Pert1. Enter the disease, or comp shock, or heart feiture. List only of	licetions that ceused the deeth and ceuse on each line.	. Do not enter the mode of de	ying, such aa cardiac o	or respiretory erres		Approximate Interval Between Onsat end Death
Immediate Cause (Finel disease or condition resulting in deeth)	a. LUNG CARCINOMA Due to (or es e consequence of):					5 MONTHS
Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Dissess or Injury	bDue to (or	r as a consequence of):				
thet initieted events resulting in death) Last	Due to (or	es e consequence of):				

Physician /Medical Examiner

19a. Informa Kobe 20e. Method 4 Done 21. Signature

Physician /Medical

Examiner

Funeral

Director

with the Marylan

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Metalls hygers. I hygers the important if lies 2's a merked other than "natural", or items 2's or 28e4 show any injury or other traumatic event, the Medical Examiner must be notified at

To Be Completed by Funeral Director

Be Completed by Physician/Medical Examiner

attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be asscuted sate has been signed by the attendin page 2 should be detached for use within 24 hours after death. To the Funeral Director: After this certificate filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

Medical Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. 25. Wes cese referred to medicel axaminer?

27. Manner of Death 2 Accidant 3 Sulcide 4 Homicide

1 Yas 2 No

29e. Certifier (Check only one) 5 Panding investigation 6 Could not be determined

Hospitel: 1 ☑Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

28d. Describe how injury occurred

24a. Was an autopsy performed?

1 Yes

1 X Yes 2 □ No

28t. Location (Street end Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29d. Dete signed (Month, Day, Year)

03/23/2000

2 No

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052

DR. ANDREW MROWIEC. 31. Date filed (Month, Dey, Year)

29b. Signeture and title of certify

MAR 2 8 2000

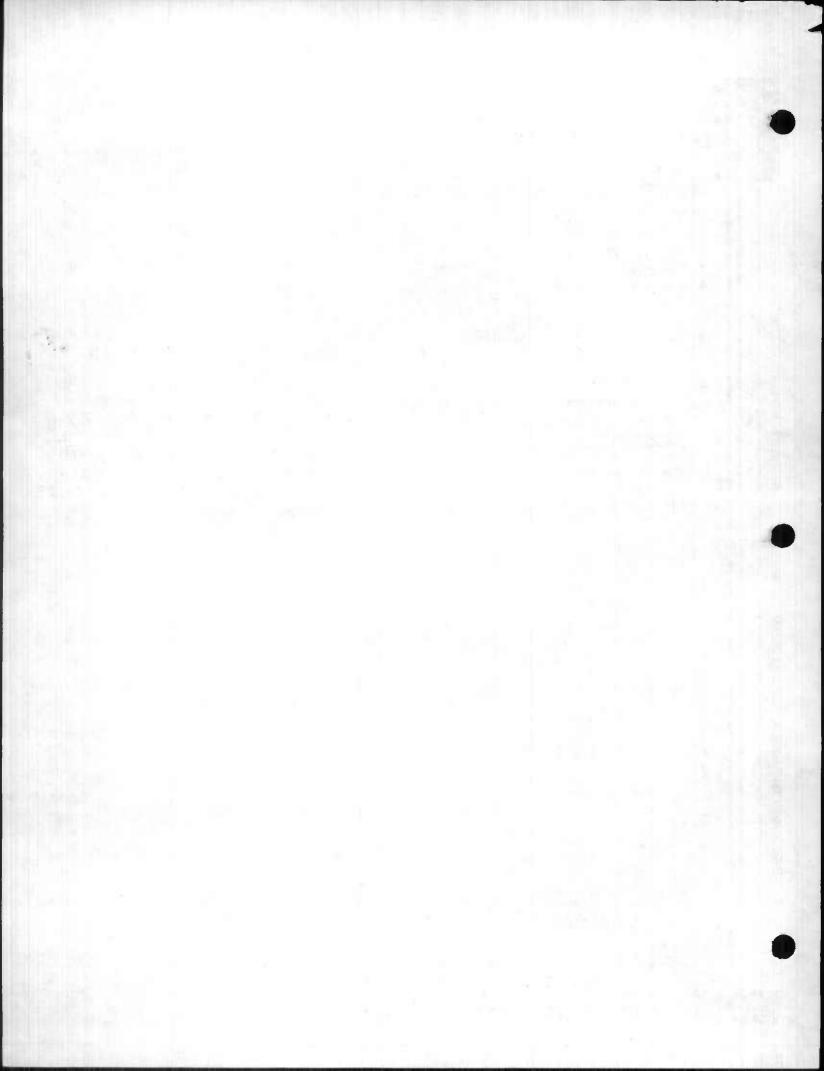
32 Registrer's Signature

29c. License number

2 47804

Registrar

State



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Daath 3. Time of Deeth Year Month **Physician** CYNTHIA 2000 HARShMAN 1237 MAR /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Nama (If not institution, giva street and number) Examiner Arundel 7. Age (In yrs. last birthday) | If Under 1 Burnie (2 low If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Sacurity Number 6. Sex 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2 F Yrs 212-78-0560 PR. 6, 1958 **Director** Usuei Residence of Decedent with the Marylend 10b. County 10a. Stete 10c. City, Town or Location 10d. tnside City Limits ir than "natural", or items 23s or 28s-f show the Wedical Exemples must be notified at 1 Yes 2 No Director EN BURNIE 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number U. S.A 21061 1225 STER DR Funeral death 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Maritei Status Black, White, atc. Peges 1 and 2 should be filed within 72 hours effer nent of Health and Mental Hygiene. 1 Never Married 2 Married 10 1 Yas 2 No Specify: altimore, Maryland 21215-0020 PV 3 Widowed 4 Divorced WHITE Completed 16a. Decedant's Usual Occupation
(Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) OWN HOME KER 7 is marked other traumatic event, t 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumame) Be ORMAN PATRICIA oll 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Route Number, City or Town, State, Zip Code) BLEN BURNIE, MD. 2106, t: If Item 27 is 7 or other tre 20b. Place of Disposition (Name of cametery, cremetory or other place) TARS ORMAN 20e. Method of Disposition Date 20c. Location - City or Town, Stete MARCH 20 permit. Peges 1 Department of H important: If Its any Injury or ot page. 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) REMATOR RO 2000 2829 HUDSON 57 21. Signature of Euneral Service Ligenses 22. Name and Address of Facility SKARDA 21224 BALT, MORE Approximata Intervel Between Onset and Death 23a. Pert1. Enter the disaesa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel Minutes lardiac disaese or condition resulting in death) Examiner Due to (or es a consequence of) Examiner)ISENSE teriosclerotic physicien end s the burial-transit that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or as a consequence of) mellitus 1A betes P.O. Box 68760 Physician/Medical Due to (or es a consequence of) nding p 5 signed by the and to be detached for 23b. Did tobecco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Wes an autopsy performed? certificate has b lirector, page 2 s 1 Yas 2 No 1 Yes 2 No i or Attanding Physician: efter death. Director: After this certific funeral director, 25. Was cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ inpatient 2 SER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) à 4 - Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the tima, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier Yel (Check only one) To the H within 24 To the F 29b. Signeture end title of certifiar Deputy 29c. Licansa number 29d. Data signed (Month, Dey, Year) 06054 1 mD me end eddress of person who complete cause of death (Item 23a) (Type, Print) William Imerica Ct. 21035 ONES, MD 695

FI

DHMH 16 Rev 6/95

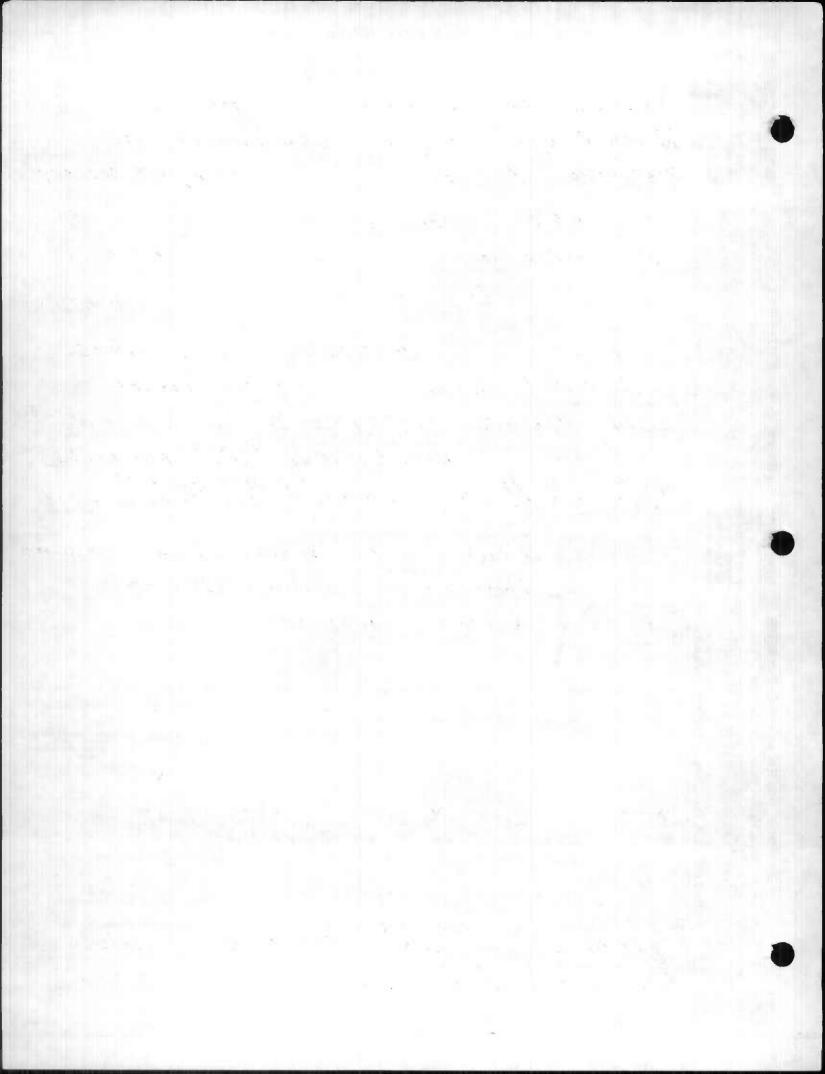
State

MAR 2 8 2000

31. Date filed (Month, Day, Yeer)

32. Registrar's Signeture

Spark



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** JACOB larch 17,2000 12:55PM HAUSWIRTH /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) Baltimore Ko 405 ranklinsquare dale ,en 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** 10M 20F Months Days Hours 219-74-5148 Usual Residence of Decedent Director 10e State r 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? EAST 2/22/ Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yas 2 ONo
If Yes, Giva
Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No 'natural', or Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondáry (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than eny injury or other treumatic event. In College (1-4or 5+) DISABLED N Maryland 17. Father's Nama' (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumama) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type Prior) TH 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 10W50N DEDT. OFAGIN Baltimore, 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stata 4 □ Donation 5 □ Other (Specify) AFMEL 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Fecility 2829 HUDSON 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiratory arrast shock, or heart failura. List only one cause on each line. Approximate fntarval Between Onset and Death Physician /Medical fmmediate Cause (Finet disease or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): r use as t Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably Onknown Completed by 24b. Ware autopsy findings available prior to complation of causa of death? 24e. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yas 2 No certificate Division of Vital 25. Was casa referred to medical axaminer? Be 26. Place of Deeth (Chack only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deal 28a. Data of Injury (Month, Day Year) 28b. Time of fnjury 28d. Dascribe how injury occurred 28c. Injury et Work? 5 Pending investigation 2 Accident 1 ☐ Yas 2 ☐ No 24 hours after death. 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of fnjury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to the cause(s) and manner stated. (Check only one) To the To To the F 29d. Data signed (Month, Day, Year) 29b. Signature end titla of certifier 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

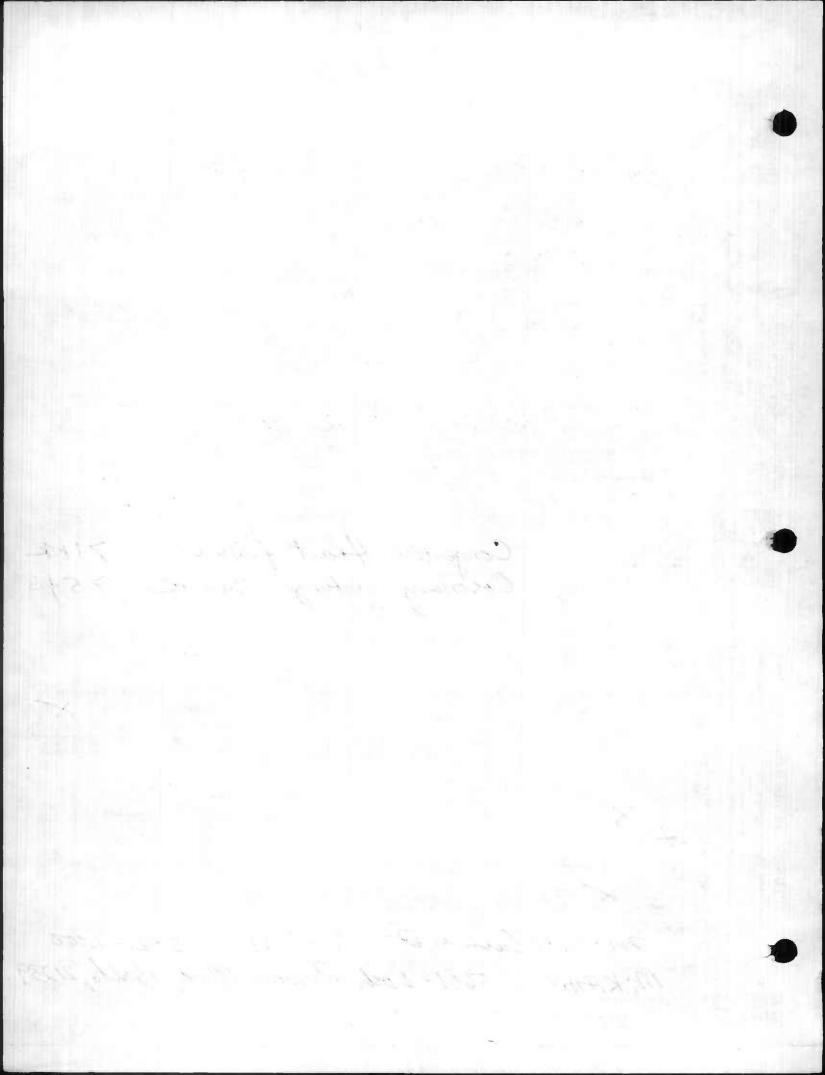
State Registrar

みたい かいつな

32. Registrar's Signetura

5601-

B Sports



TRUCKDRIVER

22. Nama and Addrass of Facility

1206 W NORTH AVENUE

20b. Place of Disposition (Nama of cematary, crematory or other place)

MT ZION CEMTERY

23a. Pertit Entai the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Dua to (or as a consequence of):

Dua to (or as a consequance of)

SEPSIS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year MARCH Z PM EDWARD HOLLEY 22 2000 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL DF BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 18 MM 2 □ F 69 Yrs. DEC 3 MARYLAND 10c. City, Town or Location 10d. Insida City Limita 1 Xxas 2 □ No N/A BALTIMORE CITY 10f. Zip Coda 10g. Citizan of What Country? 740 POPLAR GROVE ST. APT 4C 21216 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Bleck, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Specify: BLACK 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada completed)

18. Mothar's Name (First, Middla, Meidan Sumama)

MARY BARNES

740 Popular Grove St. Apt 4C, Baltimore, Md 21216

Data

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA

19b. Melling Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda)

the Meryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at death 21215-0020 should be filed within 7 and Mentel Hygiene. Maryland permit. Peges 1 and 2 should be in Department of Heelth and Mentel important: If them 27 is marked or any Injury or other traumatic ever Baltimore. Peges

Physician

/Medical

Examiner

Funeral

Director

CHARLES

5. Social Security Number

220-28-5980

10a. Stata

MARYLAND

10e. Street and Number

Director

Funeral

ð

Completed

Be

Usual Rasidance of Dacedant

1 ☐ Navar Marriad 2 ☐ Married

3 Widowed 4 Divorced

Elemantary/Secondary (0-12)

20e. Mathod of Disposition

21. Signature of Fugs

Immediete Causa (Final

17. Father's Nema (First, Middla, Last)

LEVI HOLLEY

4 ☐ Donation 5 ☐ Othar (Specify)

19a. tnformant's Name/Reletionship (Type, Print)

James Holley/ Brother

Burial 2 Cramation 3 Ramoval from Stata

10b. County

College (1-4or 5+)

leoun

Physician /Medical Examiner

buniel-transit pue Box 68760 the attending o. the 2 ۵ signed t Records, peeu ate hes page 2 s Division of Vital I or Attending Physician: after death. this After after death.

Director: After death. To the Hospital o within 24 hours aft To the Funerel DI completely filled in

Physician/Medical þ Completed Be 10

disaasa or condition resulting In death)

Saquantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cousa (Diseasa or Injury that initiated avents raaulting in death) Last Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 25. Was casa ratarred to medical axaminer? 27. Menner of Death

Medical Certification: investigation 2 Accidant 3 Suicida 6 Could not be detarmined 4 Homicida 29a. Cartifiar 29b. Signatura and titla of cartifiar V. Mohn, mo Mongan 30. Nema and addrass of person who completed cause of death (Itam 23e) (Type, Print) MONIQUE ٧.

31. Data filed (Month, Day, Year)

MAR 2 8 2000

1 Yas 2 No

5 Pending

1 Maturai

MD NOLAN,

28a. Dete of Injury (Month, Dey Year)

SINAL

28c. Injury at Work?

29c. Licansa number

RES-DOD

1 ☐ Yas 2 ☐ No

28f. Location (Straat and Numbar or Rural Route Number, City or Town, Steta)

26d. Dascribe how injury occurred

24a. Was an autopsy parformed?

1 🗆 Yas

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only ona)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner slated.

29d. Data signed (Month, Day, Year) MARCH 22, 2000

TRANSPORTATION

20c. Location - City or Town, Stata

23b. Did tobacco use contribute to the cause of death?

1 | Yes 2 | No 3 | Probably 4 | Unknown

24b. Wara autopsy findings available prior to completion of causa of deeth?

1 Yas 2 No

Approximata Intarval Between Onsel and Death

3-29-00 BALTIMORE, MARYLAND

HOSPIML BALTIMORE

62. Registrar's Signalure

1 Inpaliant 2 ER/Outpetient 3 DOA

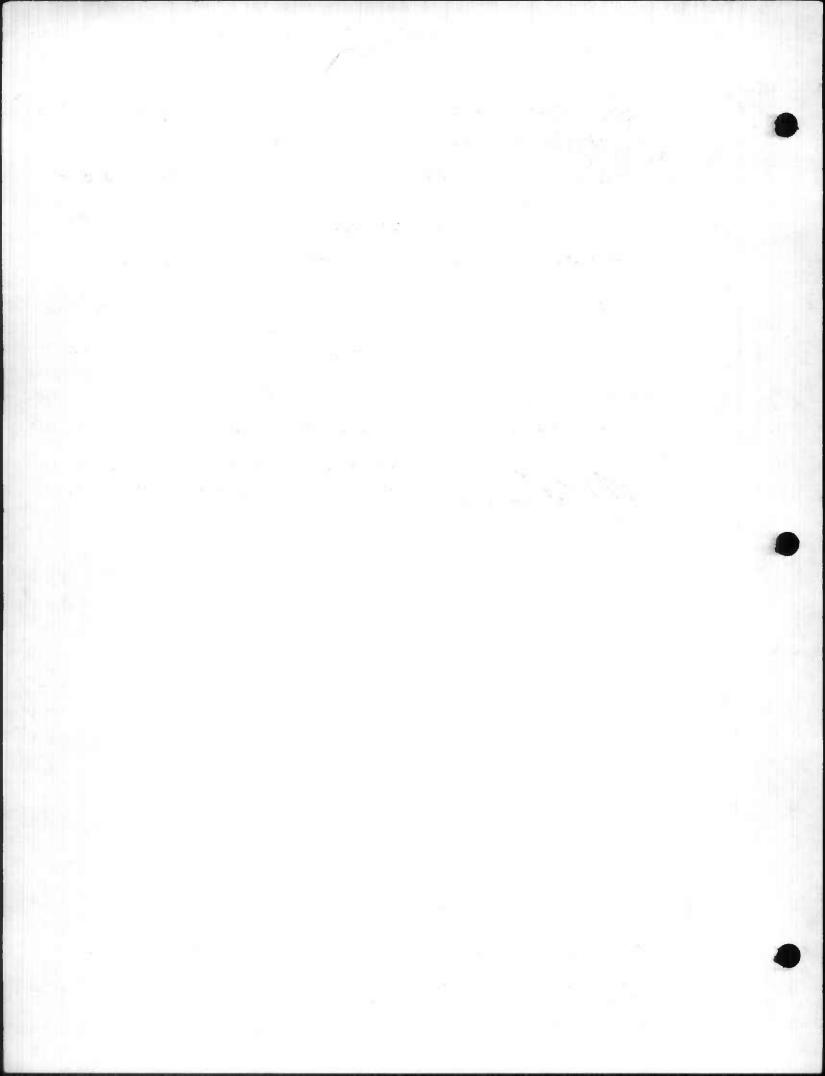
26a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28b. Tima of

DHMH 16 Rev 6/95

State

Registrar



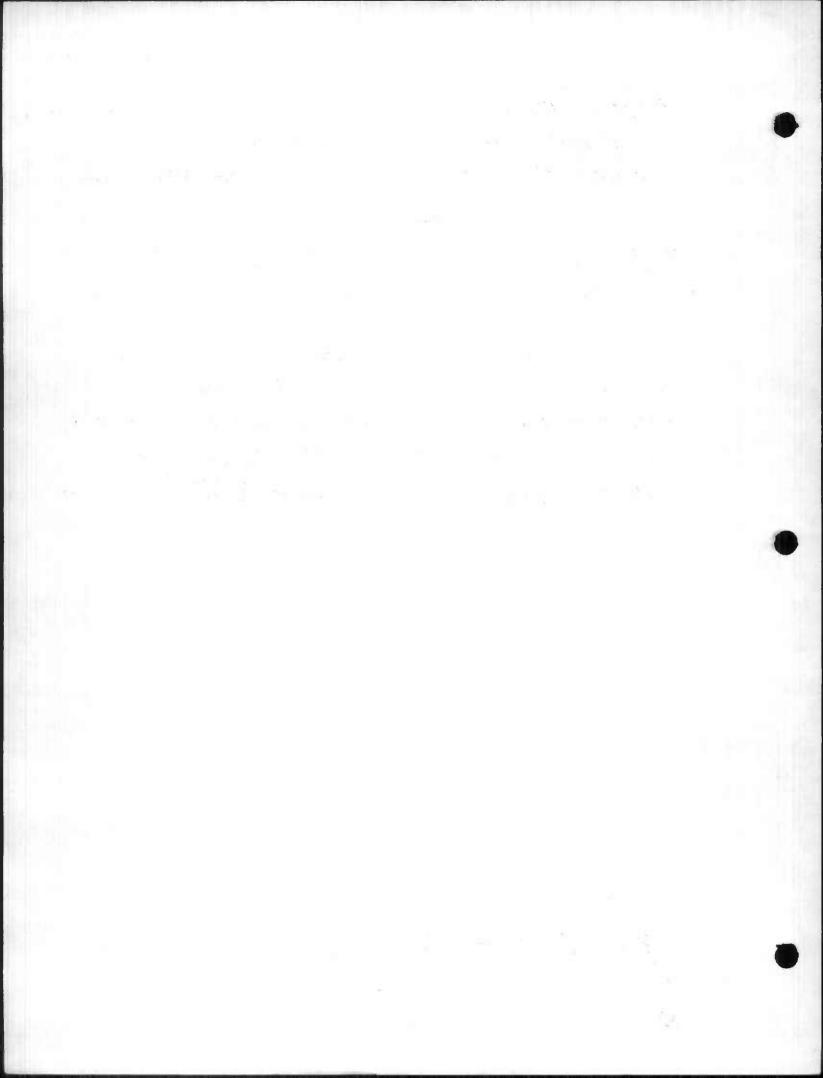
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death **Physician** Voer Elijah Haywood) march 2000 26 /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kaltimore Hospital Baltimore C.L. If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** ttom 2□ F Yrs. Director 242-14-7574 N.C. Usuai Rasidanca of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, or Modical Examinal must be notified at 10d, tnsida City Limits MD BALTIMORE 1K Yas 2 □ No Director 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 3814 BONNER ROAD 21216 U.S.A. Funeral 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Biack, White, atc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer d Department of Health and Mentel Hygiene. Important: If frem 27 is marked other than "natural" or any injury or other traumetic expenses. 1 Navar Married 2 Married 1XXas 2 ☐ No If Yes, Giva Yaar or Datas: 1 □ Yas 2XINo Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 9th NONE LONGSHOREMAN STEVEDORE 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Melden Sumema) TURNER HAYWOOD DORA BRIDGES 19e. Informent's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) BETTY HAYWOOD (WIFE) 3814 BONNER ROAD BALTIMORE, MARYLAND 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata CROWNSVILLE VETERANS CEMETERY 3-31-00 1 Sprial 2 Cramation 3 Removat from State 4 Donation 5 Other (Specify) CROWNSVILLE, MD. 5 Other (Specify) 21. Signature of Funeral Sovice Lices 22. Nama and Addrass of Facility JAMES A. MORTON & SONS 1701 LAURENS STREET BALTIMORE, MD less 21217 und 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediate Ceuse (Final disaasa or condition rasulting in daath) /Medical a. Multi system organ failure
Dua to (or as a consequence of): Examiner Septie shock

Due to (or es e consequenca ot):

Colon perforation Sequentielly list conditions, if any, laading to immediata causa. Enter Underlying Cause (Diseesa or Injury that initieted events rasulting in death) Last and P.O. Box 68760, physician Physician/Medical the Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown failure cardia Records, Completed by 24b. Were autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy performed? renal insufficue 1 Yas 2D Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director; 25. Was casa rafarred to medical exeminer?
1 Yas 2 No Be 26. Place of Deeth (Check only one) Hospital: 1 Impatlant 2 ER/Outpatlent 3 DOA Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) Certification: To 27. Mannar of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 1 SNatural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcida 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida To the Hospital or within 24 hours at To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a, Certifiar 29b. Signature and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) MO PLU Merch 26 2000 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) Sina. Hospital of Baltimore Goldstein, mo J. 32. Ragistrar's Signatura 31. Data filed (Month, Day, Yaar) State MAR 2 8 2000 Registrar

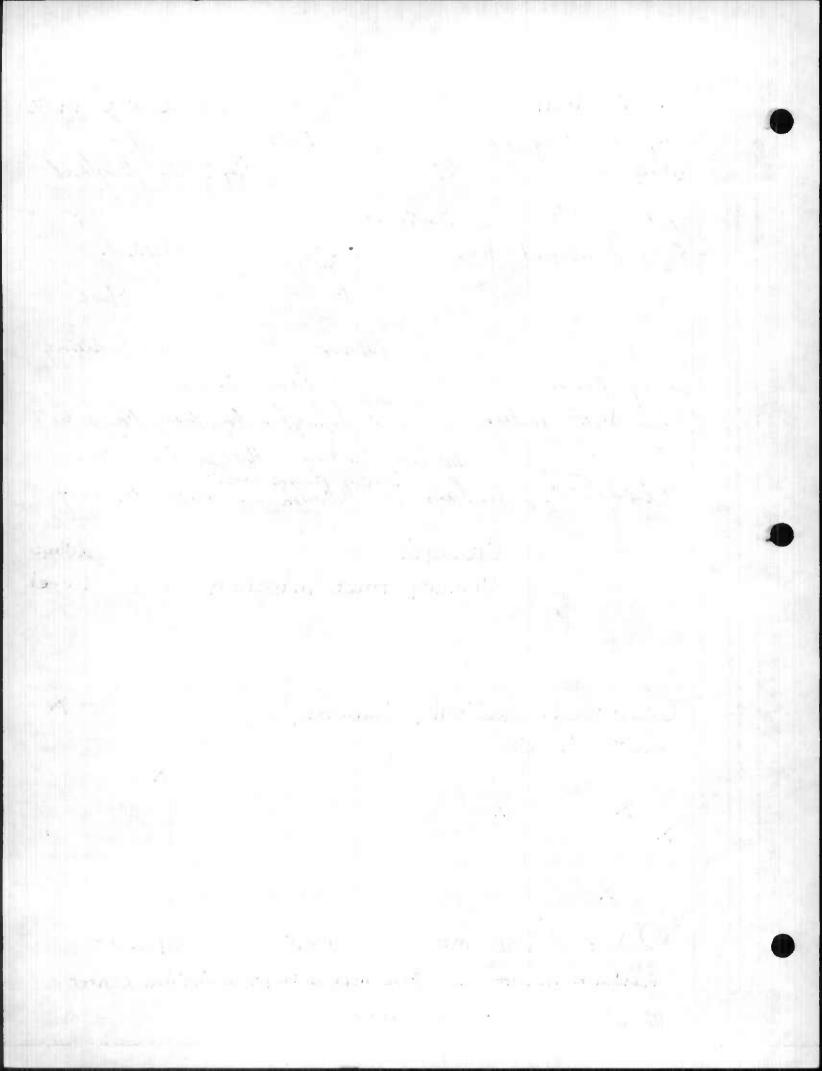
DHMH 16 Ray 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death **Physician** Dons Hal 3 3000 26 /Medical 4a Façility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Dyt **Examiner** DUVILLEU to If Under Months 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 25 F 218-28_ 5218 **Director** Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f ahow Examiner must be notified at Ballimore 1ED¥es 2□No Director Md. 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 500 pamit. Pages 1 and 2 should be filed within 72 hours after death: Department of Health and Mental Hyglene. Important: If Item 27 Ia marked other than "natural", or Items 23 any Injury or other traumetic event, the Medical Examinations. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U.S. Armed Forcas? 11. Merital Stetus Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 KNo If Yas, Giva Yaer or Datas: 1 Never Merried 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify Black 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) abover manu 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Drown 10 reroy tunn 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Palo, Scot 21217 Edna 20b. Piaca of Disposition (Neme of cemetary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Date 1 Buriai 2 □ Cramation 3 Ramoval from Stata Cemeter 4 ☐ Donation 5 ☐ Other (Specify) Balp. 2. Nama and Addrass of Facility Douglas, Finera 21. Signeture of Funarai Service-Licenses Sarvice 1701 Balo McCullah 01 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respi shock, or heart feiture. List only one cause on each me. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Finei Urosepsis 2 days disaasa or condition rasulting in deeth) Examiner Examiner week trac rinarc or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata causa. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. Completed by Physician/Medical Dua to (or as a consequence of): for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown Cerebrovascular accident 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Seizure disorder completion of cause of death? 1 ☐ Yas 2 ☐ No certificata 25. Was case rafarred to medical examinar? Be 26. Place of Death (Check only one) 1 Inpatient 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural
2 Accidant 1 ☐ Yes 2 ☐ No - Thin 24 hours after death. To the Funeral Director: A 6 Could not be datarmined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steled. Medical 29e. Certifier tely (Check only one) 2 29b. Signatura and titia of certifia 29c. License number 29d. Data signed (Month, Day, Year) 20 MD 20315 26100 30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) Randal P. Riesett Johns Hopkins Bayview medical Center MD 31. Data filed (Month, Dey, Year) 32. Registrar's Signatura State Registrar MAR 2 8 2000

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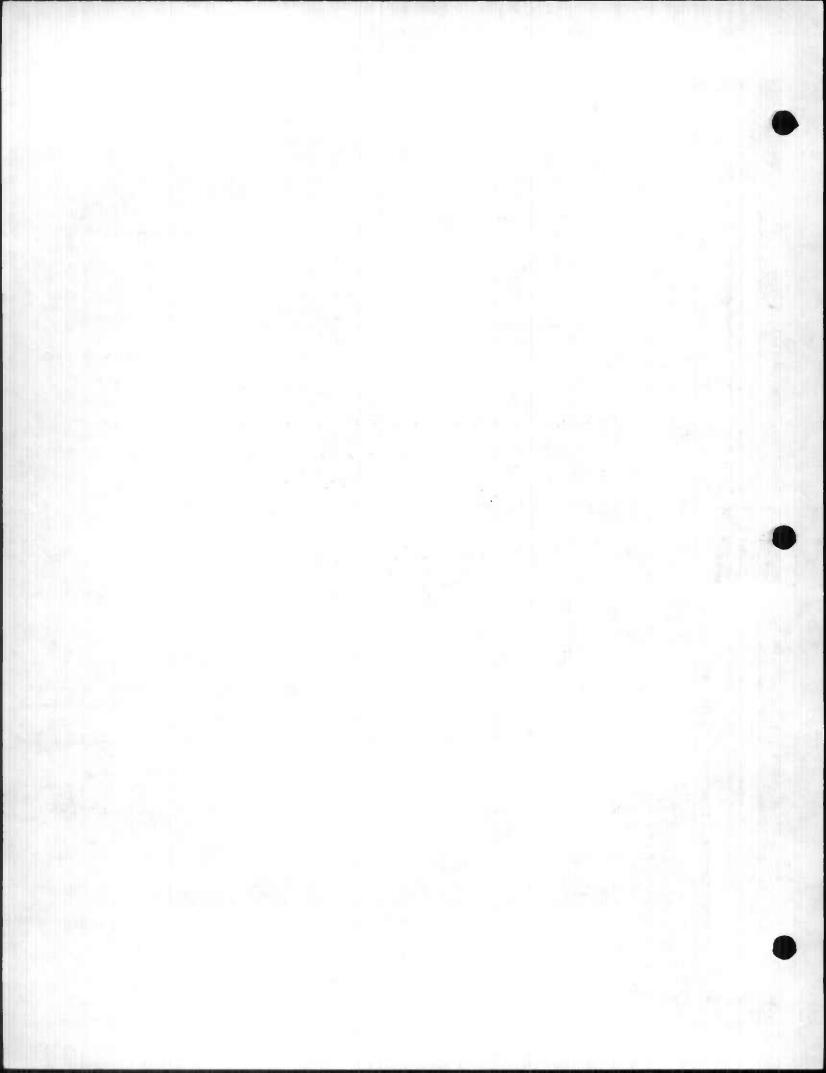


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Year Month **Physician** Frances Ann Hugg March 23 4:40 pm 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1165 Green Holly Annapolis Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 23,1950 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1□M 2⊠F 214-54-9313 Yrs. Director 50 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or hams 23s or 28s-f show the Medical Examinar must be notified at 1XX es 2□No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1501 Cedar Park Road death v 21401 IISA Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) e filed within 72 hours after d il Hygiene. other than "natural", or itam 1 Never Married 2 Married 1 Yes 2N No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 Yes 2√No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hyglert Important: if Item 27 Ie marked other that any Injury or other treumatic avent, that pages. 12 Clerical Anne Arundel County 17. Father's Name (First, Middle, Last) 16. Mothar's Nama (First, Middla, Maiden Sumame) 8 Louis F. Trott Anne Kirby 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles H. Hugg, Jr. (Husband) 1501 Cedar Park Road, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 03/27 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 □ Cremation 3 □ Removel from Stete 4 Donation 5 Other (Specify) Hillcrest Cemetery 2000 Annapolis, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Approximete Intervel Between Onset and Death e, of complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, List only one cause on each line. Physician /Medical Immediata Cause (Finel disease or condition resulting in death) Examiner Examiner and The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): and by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 50 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed certificate has Dege 2 1□ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Home 1 Yes 2 No P this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Afferi Certification: 1 Natural 5 Pending investigation death. 1 Yas 2 No • Euneral Director: A state of Funeral Director: A state of filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 26t. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 Homicide ò 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to tha cause(s) end manner es stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) iner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, data end place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Dete signed (Month, Dey, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 231 Annapolis mozique m.0 600 31. Date filed (Month, Day, Year) 32. Registrar'a Signature State MAR 2 8 2000 Registrar

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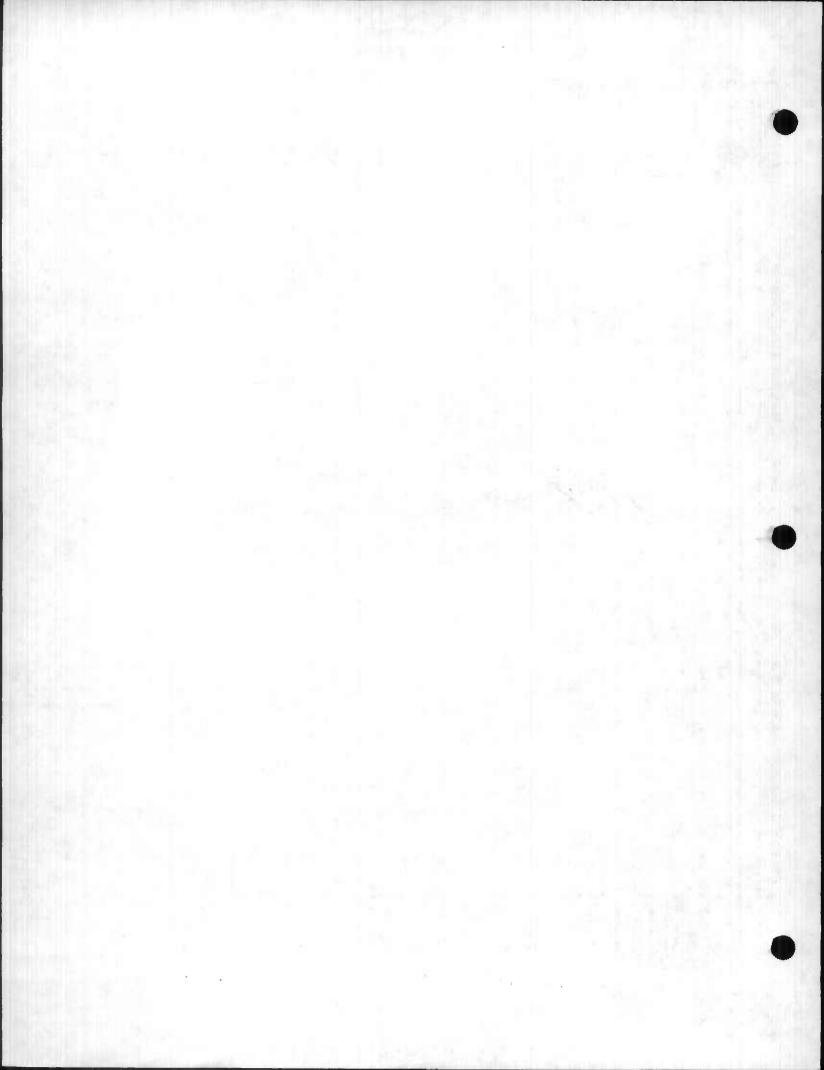
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State of Maryland / Department of Health and Mental Hygiene 0 0 9 9 1 item 5.18 per informant G787 9/26/00 vf Certificate of Death

	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death						
ysician Medical	EILEEN HOLZWORTH	MARCH	23 2000	11:00 pm				
viedicai caminer	4a Facility Name (If not institution, give street and number) 4b. City, To	own, or Location of Death						
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neral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24 Hrs. 8. Date of Birt		Birthplace (State or Forei Country)				
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Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Or fit Yes, specify Cuban, Mexica	an, Puerto Rican, etc.)	Black, W					
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unent of Health and Men tant: If Item 27 le marke ijury or other treumatic.	HANSON	SABELLE TELL						
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb	ber or Rural Route Number	er, City or Town, State	e, Zip Code)				
	Francine J. Rosenberger/Grandaughter 2329 N. Van	nburen Ct.,	Arlington	, VA. 22205				
	20a. Mathod of Disposition 20b. Place of Disposition (Name of	Date	20c Location - City	or Town State				
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once	21. Signature of the community of the co							
	1206 W NORTH AVENUE							
	23. And the disease, or complications that caused the death. Do not enter the mode of dying, such as mock, or heart failure. List only one cause on each line.	s cardiac or respiratory a	rrest,	Approximate Interval Between				
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Pe		24a. Was	an autopsy 24 emed?	 Wera autopsy tindin available prior to completion of cause 				
To Be Comple				of death?				
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Ca	29a. Certifier 1☐ **Certifying Physician: To the best of my knowledge, death occurred at the time, date at Check only 2☐ **Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	and place, and due to the sath occurred at the time.	cause(s) and manne date and place, and	res stated. due to the cause(s)				
Medical Certification:	one) and manner stated.							
Σ	29b. Signature and title of cartifier 29c. License number	ad	29d. Date signed (M	onth, Day, Year)				
	The man of man monish 14 6	99	3/24/0	0				
	30. Name and address of person who completed cause of death (from 23s) (Type Print)							
	30 Name and address of person who completed cause of death (Item 23a) (Type. Print)	1 -						
	30, Name and address of person who completed cause of death (from 23a) (Typa, Print). (TV(AUYY) M Branch 1245 Eastern Blvs	d Balt	0 212	-21				
	Grebory Wm Branch 1245 Eastern Blva	d Balt	0 212	-21				
State Medical Certification	Gregory Wm Branch 1245 Eastern Blva	d Balt	0 212	-21				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month JOEL DAVID **HESS** MARCH 26, 2000 1:00 A.M. 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GENESIS ELDERCARE - HERITAGE CENTER DUNDALK BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months 1⊠M 2□ F Deys Hours 217-36-4354 59 MAY 23, 1940 Usuat Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas ZX No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1313 THIRD ROAD 21220 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify. WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) ZOO ATTENDANI BALTIMORE ZOO 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) **JEROME HESS** JOAN FRIEDENBERG 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) L. STEPHEN HESS / BROTHER 107 RIVER OAKS CIRCLE - BALTIMORE, MD 21208 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 Cremation 3 Removel from State 4 Donetion 5 □ Other (Specify) BNAI ISRAEL CEMETERY 3/27/00 BALTIMORE, MD 21. Signature Funeral Service Listinsed 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that advised the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, teeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MONI Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24e. Was an autopsy performed? completion of cause of death? 2 No 1 Yas 1 Yes 2 No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 1 Neturet 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one)

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Physician

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Examiner

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7 is marked other than "natural", or items 23s or 28a-f show trsumstic avant, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene, important: if Itam 27 is marked other than "natural". *** In any injury or other traumatic avairations and injury or other traumatic avairations.

Physician /Medical

Examiner

the Maryland

Division of Vital Records, P.O. Box 68760 Completed Be 10 or Attend ster death Director: / filled in by To the having a series of the funeral Di-

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State Registrar

31. Dete filed (Month, Day, Year)

32. Registrar's Signature MAR 2 8 2000 > Lener

chuse of peath (flor) 23a) (Troe, Printy

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and menner as atated.
2 Medical Examiner: On the basts of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated.

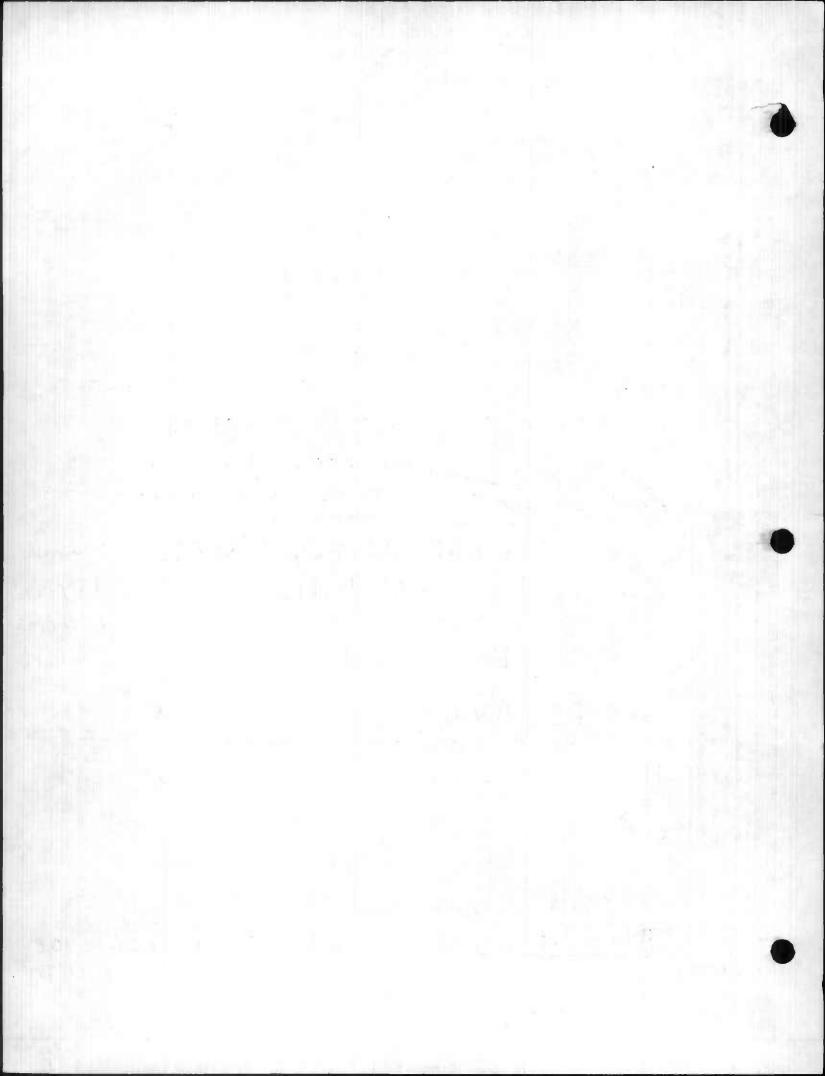
29d. Date signed (Month, Day, Year) March 26, 2000

CHIE HIGHWAY, BALTIMORE

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09981. AMENDED ITEM #23a pt I1& I PER MD G781 3/28/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ANNIE JOHNSON 6:00 PM MARCH 2000 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N.H Baltimore orest atunsulla If Under 24 Hrs. 8 De Haven 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6 Sev 9. Birthplece (State or Foreign Country) **Funeral** 1□M 2×F Days Yrs. Director -15-03-5043 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at BaHimore 1 Nes 2□ No Director Ma NA 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2807 Elsinore 2/2/6 Avenue 15.4 Funeral death 12. Wes Decedent Ever In U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Detes: 11. Marital Status Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Avon Coperation of Health and 2 should be filed within Coperation of Health and Mental Hygiene.
Important: if item 27 is marked other than any injury or other trainment. Elementery/Secondary (0-12) College (1-4or 5+) Representative unk 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bryant N. Thigpenn George Nellie 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltond 2/216 Son 2803 Ekinore reorge ohnson, Jr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Calvary Cenetery 3-25-00 Anne 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Fecility

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enter the mode of dying, such as cardiec or respiretory errest, nature of Funeral Service Licenses Balto, Md 21215 Grenne 1000 that caused the death. Do not enter Approximete Interval Between Onset and Death Physician ATHEROSCLEROTIC CARDIOVASCULAR DISEASE mediate Cause (Final RONAL disease or condition resulting in death) Hears Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 8 Due to (or as a consequence of): ettending ò P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? the RENAL FAILURE signed by 1 Yes 2 No 3 Probably 4 Unknown Records. page 2 should b 24b. Were eutopsy findings evalleble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed certificate 1 Yes 2 3 No 1 ☐ Yes 2 ☐ No 25. Was case referred b medical examiner? Be 26. Place of Death (Check only one) Other: Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 20 No 10 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Medical Certification: 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital of or Attending P To the Hospital o within 24 hours ef To the Funeral Di

Registrar

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AROND 25 31. Date filed (Month, Pay, Year) MAR 2 8 32. Registrar's Signature

4 Homicide

29b, Signature and tall of certifier

29a, Certifler

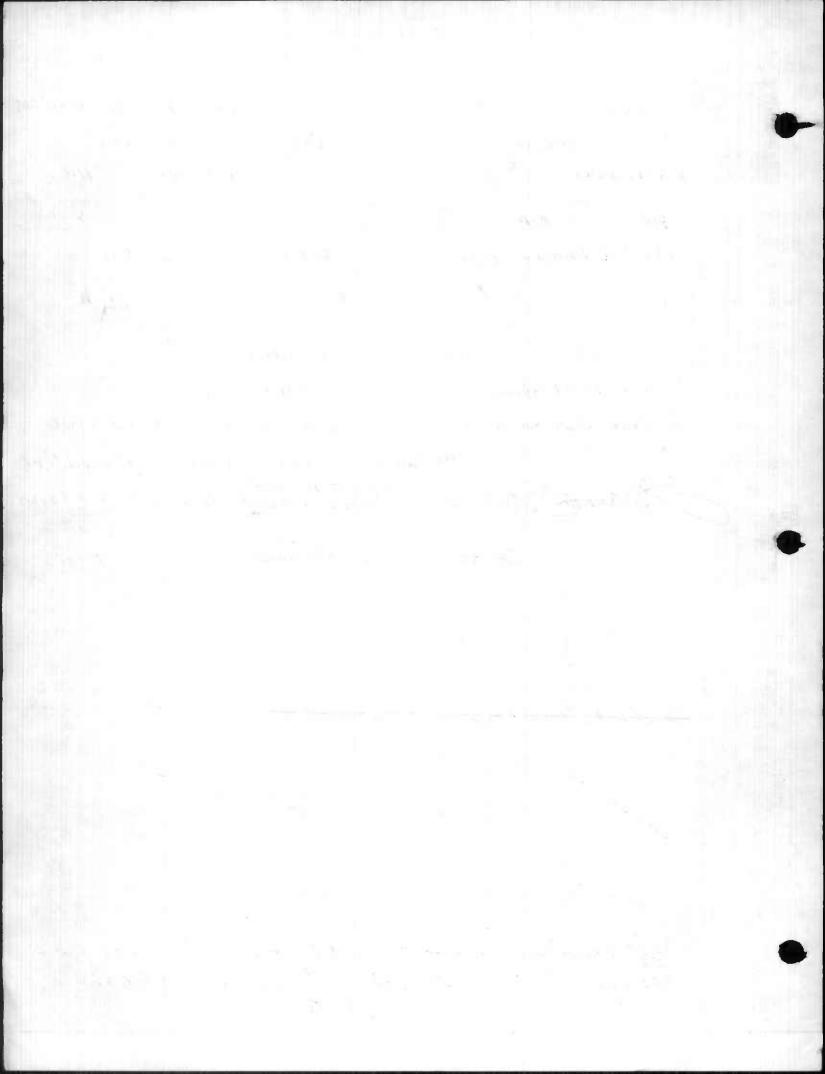
30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Mai

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) MANCHEZ ZEOD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09982 Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Data of Death 3. Time of Death Mildred Jefferys Year **Physician** MARCH 23 2000 10:00 P.M. /Medical 4a Facitity Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKlin SqUARE 5. Sociel Security Number 0 6. Sex 7. Age (In yrs. last birthday) BATTIMORE Cenler dAle HOS 8. Date of Birth (Month, Day, Year) Jan 19 1924 Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 20 F 214-14-1186 Director Maryland Usuet Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inaide City Limits MD Baltimore Essex 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 807 Middlesex Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, 11 Meritel Stetus Black, Whita, etc. 1 Yes 2 No If Yes, Give Year or Detas: 1 Never Merried 22 Married natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) Homemaker own home 8th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be is marked Charles Eugene Waddell Rose Smith 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 807 Middlesex Road Victor Jefferys /husband Baltimore MD 21221 mportant: If Item 27 20b. Place of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑Buriel 2 ☐ Cramation 3 ☐ Ramovat from State Garrison Forest VA Cemetery3/28/2000 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Connelly Funeral Home of Essex llu 300 Mace Ave. Baltimore Maryland oun 21221 23a. Pert1. Enter the disease, or complications that caused the death point anter the mode of dying, auch as cardiec or respiretory errast, abock, or hear feiture. List only and cause on each line. Approximeta Intervel Between Onset and Deeth **Physician** transdicte Cause (Final disease or condition resulting in deeth) /Medical HOURS HYDOXCMIA Examiner Due to (or es a consequence of): Examine IERMINAL EXTUBATION physician and s the burial-trans Sequentielly tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last c. Chronic LymphocyTic Leukemix Box 68760, Physician/Medical P.O. Pert tt. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yea 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes an autopsy Be Completed performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medicat 26. Place of Deeth (Check only one) Hospitel: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Medical Certification: To 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred I or Attending Fatter death. After Division Neturet 2 Accident 5 Pending investigation **fnjury** 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours at To the Funeral D Cartifying Physician: To the best of my knowledge, death occurred et tha tima, date and place, end due to the cause(s) end manner es stated. Madical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and dua to the cause(s) and manner stated. 29a. Cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of or

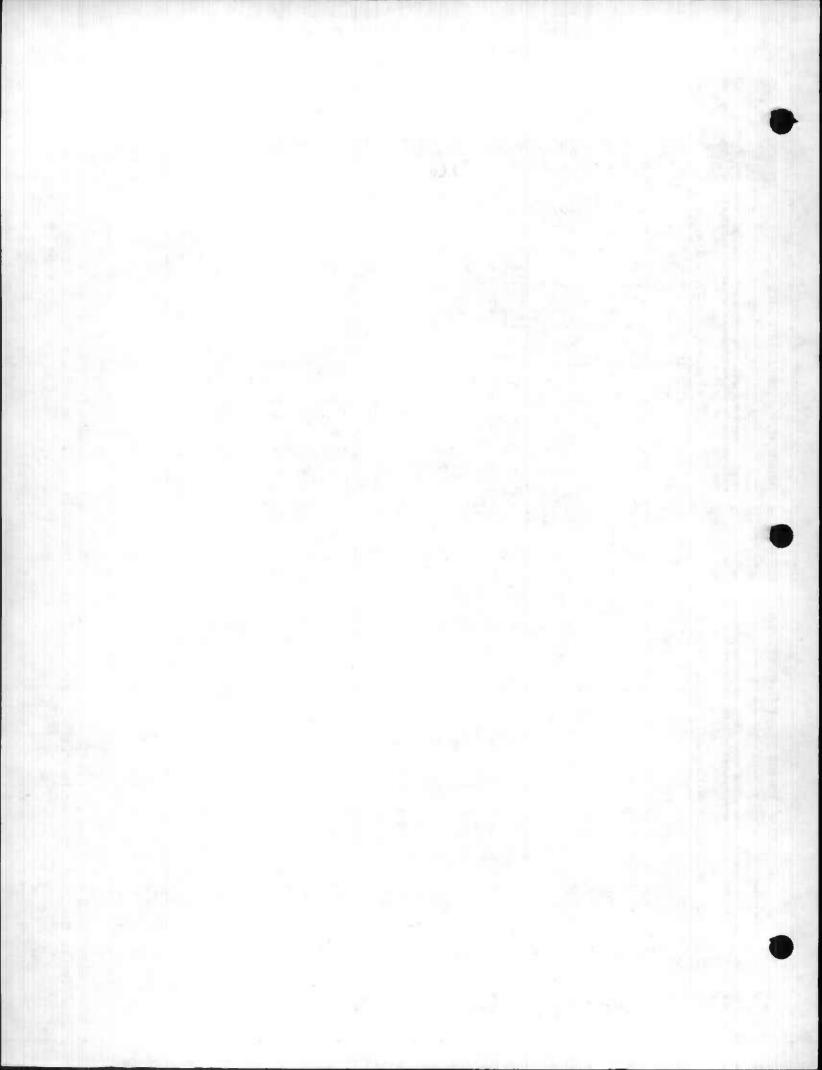
State Registrar DR. MARYbeth Anderson 9000 FRANKlin SeyARE DR. BALTIMORE Md

with

address of person who completed cause of death (ftem 23a) (Type, Print)

32. Registrer's Signature

31. Dete filed (Month, Dey, Year)
MAR 2 8 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Day DAVID March 17, 2000 1852 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/A Hours Min. B. Date of Birth Month, Day, Year)

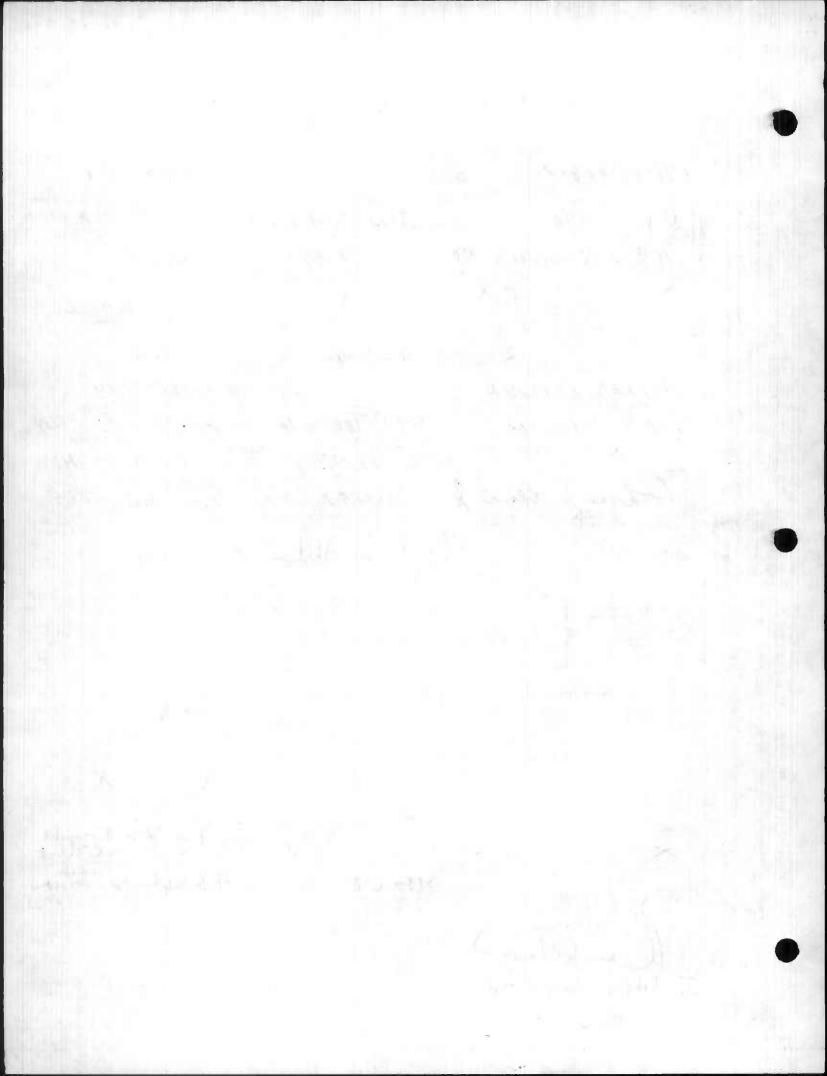
DEC-21/94 If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country) **Funeral** Days M 2DF Months Usual Residence of Decedent Director 10a. State 10b, County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show CORNERS Yes 2□No Director -INTON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? OWBLOOK 13. Was Decedent of Hispanić Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 YNo
If Yes, Give t 4. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 20 No Specify à 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t 6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiana Important: If Nem 27 is marked other that any lijury or other traumatic event, tra I ponds. AUTO MECHANIC 17 Father's Name /First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) Be GOLDSTEIN FKED KALLMAN t 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) SoloMer SOUTH DAY TOWA 20b. Place of Disposition (Name of cemetery, crematory or other p MACH 20 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 R
4 Donation 5 Other (Specify) 3 Removel from State 170-CO. 22. Name and Address of Facility 21. Signature of Patieral Service Lie 23a. Part t. Enter the disease or complications that caused the death. shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediata Cause (Final disease or condition rasulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by t d be detect 2 No 1 Yaa 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy 1 Yes 2 No 2 No certificata Division of Vitai To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠ Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? t Natural 5 Pending investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 Suicident 3 ☐ Suicide 6 Could not be Routa Nymbe 4 Homicide Nevs t. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifia 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sky O.C.M.E. March 20, 2000 30. No d cause of death (Item 23a) (Type, Print) Hon Late 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 28 2000 Docks Registrar Gaper

DHMH 16 Rav 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Day Physician Kacher Delores 4:30pm march 21,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner Johns Hopkins Bayview Medical

5. Sociel Security Number

6. Sex

1 M 2XIF

7. Age (In yrs. last birtho Baltimore Center 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow ahow 1 Yas 2 No Funeral Director MD. 10e. Street and Number 10g. Citizen of What Country? ò 5302 21206 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. . Race - American Indian, Black, Whita, etc. Armed Forces?

1 Yes 2 No
If Yes, Give filed within 72 hours effer 1 Never Married 2 Merried 21215-0020 ò 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OPERATOR Baitimore, Maryland 18. Mother's Nama (First, Middla, Maiden Sumame) 17 Father's Name (First Middle Lest) Be KOERBER BOOTH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Melvin AVE. BALTINGLE, MD 21206 CER-BER 5302 20b. Place of Disposition (Name of cometery) crematory or other place) MARCH 24 20a. Mathod of Disposition 1 Buriat 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2000 21. Signature of Beneral Service Upensee 3218 HUDSON ST BALTIMONE, HD. 21224 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and only one cause on each line. Approximata Interval Between Onset and Death Physician Immediata Causa (Final disease or condition resulting in death) /Medical Congestive heart failure days Examiner Completed by Physician/Medical Examiner failure days Acute renal or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) a months colon cancer Box 68760, Due to (or as a consequence of) US0 88 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? of Vital Records, P.O. 1 Yaa 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? certificate has 1 Yes 2 No 1 ☐ Yes 2 No funeral director. 25. Was casa refarred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 1 6 Could not be detarmined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Dete aigned (Month, Day, Year) 29b. Signature and title of certifier 21,2000 and address of person who completed cause of death (Item 23a) (Type, Print) Rennert-Ariev Jadi 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

2000

professional acceptance of the contract of the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death .30 AM **Physician** Hvun S. Kwak Marc 2000 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 13, 1949 Birthplace (State or Foreign Country)
 Korea 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 F 605-52-6415 50 Yrs. Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene. other than "natural", or flema 23a or 28a-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director MD Howard Columbia 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 5303 Columbia Road Apt B 21044 Korea death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Korean by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within 72 Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any Injury or other traumatic event othes. Be Young Ho Jeon (unk) 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5303 Columbia Rd. Apt B, Columbia MD 21044 Suk Soon Kwak Husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 3/28/00 Marriottsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) Crestlawn Cemetery 21. Signature of Euneral Service Licensy 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final 2 month diseese or condition rasulting in death) Examiner Due to (or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last physician a the burish Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown à 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 X No t ☐ Yes 2 No Be 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1□Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 1 Neturel 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, lerm, street, factory, office building, etc. (Specify) 4 Homicide ŧ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

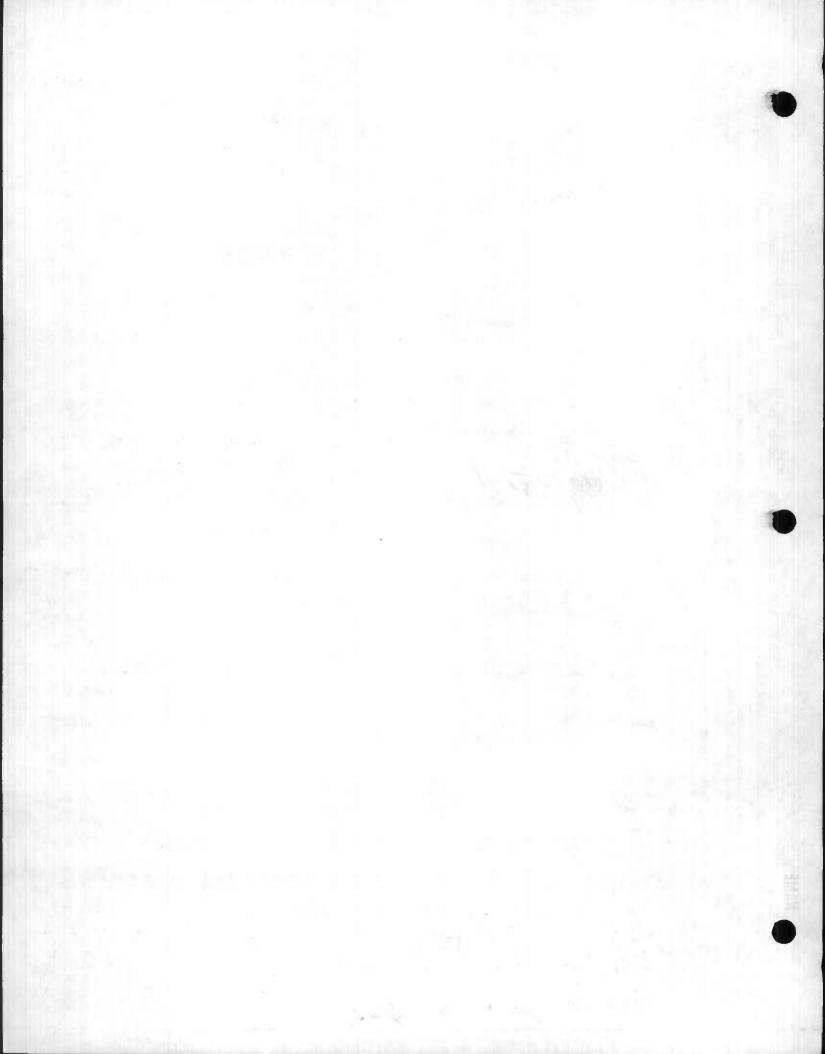
[2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. Medical 29a. Certifie (Check only one) 20 To the Mithin 2 IA the comple 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier Ke 81ders 182 aum 30. Name and address of persons who completed cause of death (Item 23a) (Type, Print) 900 Caton 31. Dete filed (Month, Day, Yeld) 32. Registrar's Signature State

Registrar

MAR 2 8 2000

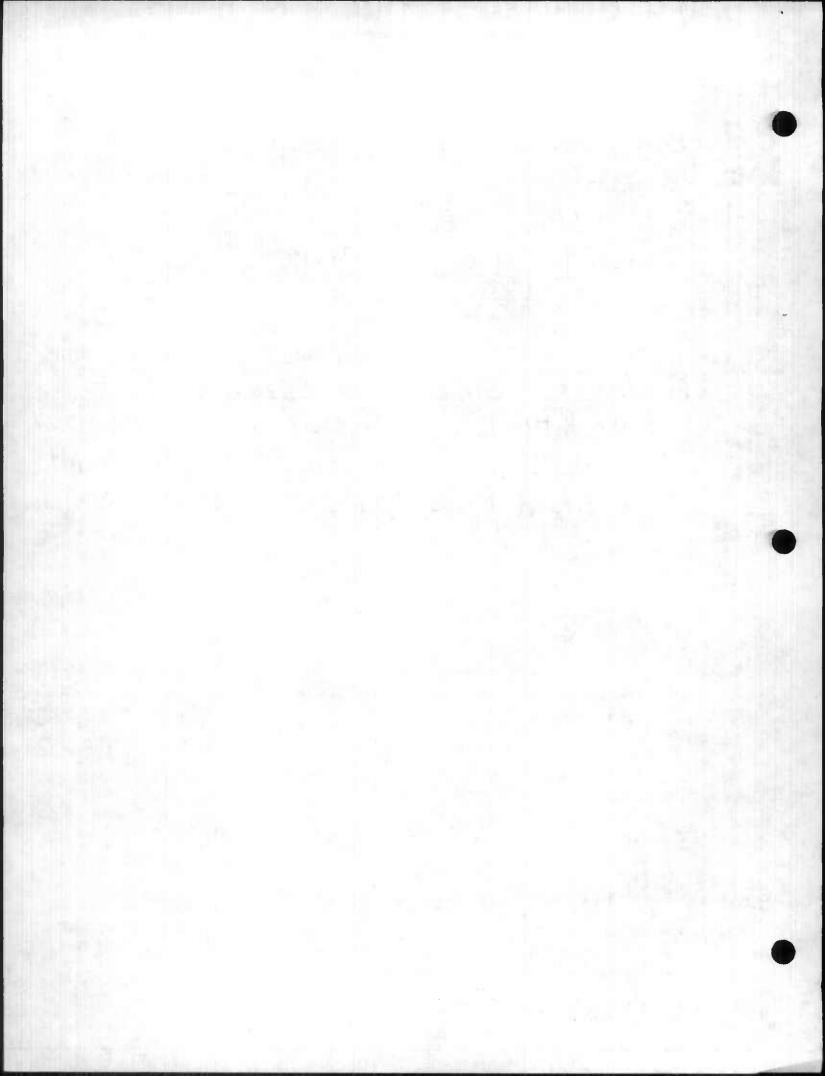
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State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death Reg. No.							2200	
	Physicia		1. Decedent's Name (First, Middle, Last)			0 = 1 1	2. Date of Death Month	Day	Year 3.	Time of Death
ų,	/Medica		VERNEL		KITI	RELL	MARCH	24 3	2000 5	5 3 P.N
	Examine Funeral Director		4a Facility Name (If not institution, give Bon Secoul 5. Social Security Number 6. Secoul 12-76-2508	rs Hospi	birthday) If Undar Yrs. Months	Balti		4c. County	IIA	(State or Foreign
	or death with the Maryland ttems 23s or 28s-f show	Director	10a. State 10b. County Maryland 10a. Street and Number	Bo	own or Location 10f. Zip	Code	10	g. Citizen of V	1	nside City Limits Yes 2 □ No
20	or he	by Funeral C	11. Marital Status 1 Never Married 2 Married 3 SWidowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forcas? 1 Yes 2 No If Yes, Give	If Yes, spec	DID OF Specify:	Specify Yas or No- rto Rican, etc.)		S A - American In k, Whita, atc.	dian,
215-0020	"natur	Completed	15. Decedent's Edu (Specify only highest grade Elementary/9econdary (0-12)		Sa. Decedent's Usua (Give kind of wor life. PO NOT us	rk done during most of we		6b. Kind of Bu	siness/Industry	
and 21	should be filed within and Mentel Hygiene. marked other than imatic event, the Mentel Hygiene.	To Be Com	17. Father's Name (First, Middle, Last)	0.11.	Hom	emaker 18. Mother's Ne	ame (First, Middle, M	OW laiden Surnam	n H	ome
Maryia	0000		19a. Informant's Name/Rejetionship (Ty	91115 pe. Print) (SON) 1	9b. Mailing Address	(Street end Number or F	aubeth Pural Route Number, Ue, B	City or Town,	State, Zip Code	1224
more,			20a. Method of Disposition 1 Burial 2 Cramation 3 R 4 Donation 5 Other (Specify)	ceme	of Disposition (Nantery, crematory or o	ne of ther place)		Oc. Location -	City or Town, S	Stata Md
Balti	permit. Page Department of important: If eny injury or page.		21. Signature of Funeral Service L. German	* L. RUM	22. Nama an	d Address of Facility	ss Fun	eral	Home	71216
	Physician	14	23a. Part / Enter the districts, or complishook or heart failure. List only or	cations that caused the death. Due cause on each line.	o not enter the mod	e of dying, such as cardia	ac or raspiratory arre	est,	Inte	proximata rval Between set and Death
	/Medical Examiner		Immediate Cause (Final diseasa or condition resulting in death)	Due to (or as	a consequence of):	BRO-VA		R ALL		DAYS
6 0,	ortificate be executed ing physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events		a consequenca of):	EPHALO	PATHY		1	DM / 3
BOX 68/60	ng p as	in/Medical	that initiated events resulting In death) Last	Due to (or as	a consequence of):				i	
	death	by Physician	Part It. Other eignificant conditions cor	tributing to death but not resulting	g in the underlying o	ause given in Part I.	23b. Did to	bacco use co	ntribute to the	cause of death?
S, P.O	ires that the death ce signed by the ettend d be detached for us		- HYPERTE	NDON			1 🗆 Ye	90 2□ No	3 Probably	4 Unknown
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× = ×	Physician: The ribis certificate and director, pag	9	25. Was case referred to medical examiner?	lospital:		Other	eath (Check only on			
5	4 4 7	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2LIER			Home 5 ☐ Reside			
DIVISION	Afte fund	edical Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Dey Year) 28e. Place of Injury - At home,	M	tec. Injury at Work? 1 ☐ Yes 2 ☐ No 7, office	28f. Location (St	reet and Numb		ute Number,
ລັ			29a. Certifier (Check only 2 Medical Exam)	building, atc. (Specify) sician: To the best of my knowled her: On the bests of examination				use(s) end me		
	To the vithin 2.	Med	29b. Signature and title of certifier	and manner stated.	290	c. License number	2	d. Data signe	d (Month, Day,	Year)
	B	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bon Secons Most, Sudhir D. PATEL 2000 W. Bollinger St. B.						ol. no	0,2122	
	Stat	е	MADOS	2000	, jiy	Ann. V				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Day Year **Physician** Benjamin R. Kristoff 20 MARCH 2000 /Medical 01:50 AM 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Days Months 1 Q M 2 □ F Director 276-38-8982 Dec 5, 1942 Ohio Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No Director 28a-t MD **Baltimore** Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð flame 23a 21117 U.S.A. 15 Olive Lane Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Merital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 'natural', or 1 Yes 2 No Specify: altimore, Maryland 21215-002(Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) Motorola 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 and Mental Frances Klein Benjamin Kristoff 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Nem 27 any injury or other to 15 Olive Lane Owings Mills, MD 21117 Mrs. Phyllis Randall 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel trom Stete 4 □ Donation 5 □ Other (Specify) 03/24/00 Sykesville, Maryland All County Cremation Services, Inc. ture of Funeral Service License 22. Name end Address of Fecility Slack Funeral Home, P.A. Mer53/ 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical VENAL cell 6 months Examiner Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. signed by the 1 Yes 200 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy tindings avsilable prior to completion of cause of death? should Completed 24a. Wes an autopsy performed? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of tnjury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier (Check only one) 29b. Signature and titligraf certifie 29c. License number 29d. Date signed (Month, Day, Year) March 20, 2000 mo

State
Registrar

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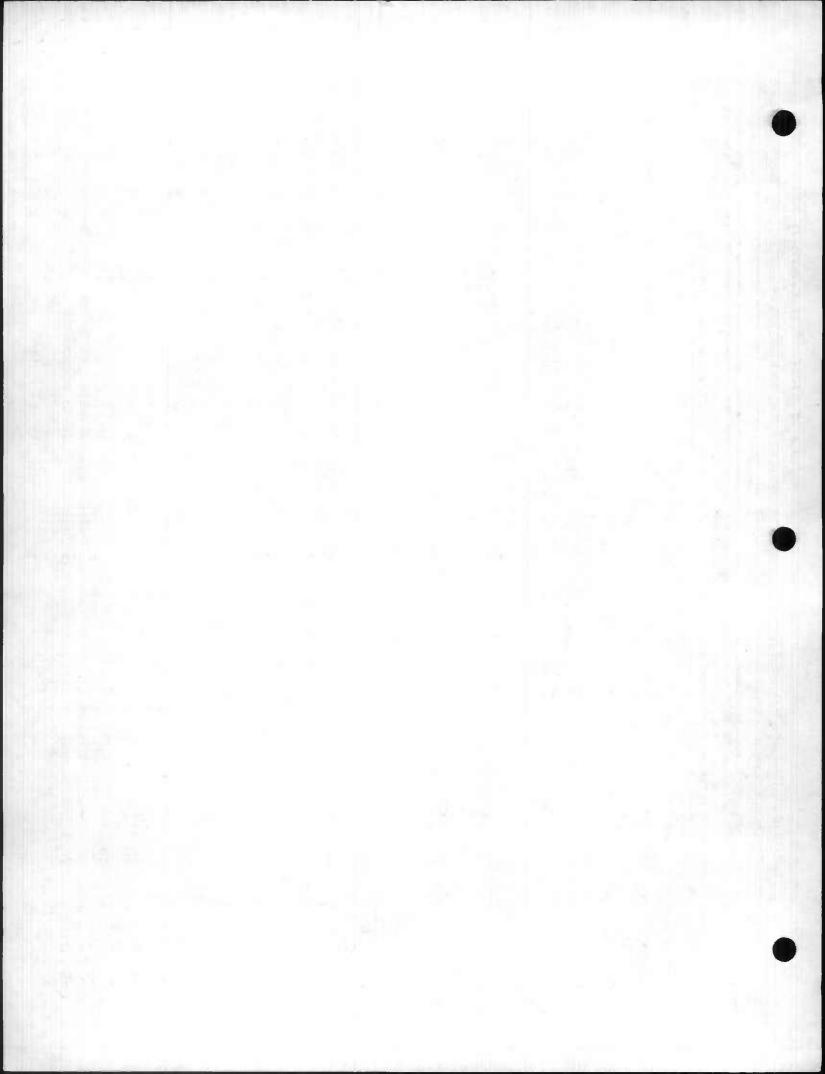
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32. Registrar's Signature

N. Charles St. Bulto. Md 2120g

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

MAR 2000



LOPATA, HELEN

		Please 1	Type or Print in Bla State of Maryland	/ Departm	ent of			•	ble. 0 9	988	
Physi	oian	1. Decedent's Name (First, Middle, Last)	1			2. Date of De	eath Day	Year /	na of Death	
/Mec		Helen	Α	Lopat	a		march	20 20	00 6.8	13pm	
Exam	iner		ire Hospital	cente	1	46. City, Town, or L ROSEDA	le	Balt	imere		
Funera Directo		5. Social Security Number 6. Se 165-20-2528 1. Usual Residence of Decedent	7. Age (In yrs. last		nder 1 Year iths Days		8. Date of Bi (Month, D	rth ay, Year) 5-24	9. Birthplece (St Country) PA	ate or Foreign	
with the Maryland t or 28e-f show be notified at	ector	10s. State 10b. County	imore 10c. City, T	own or Location Roseda			1			de City Limits	
th with the Maryla 23a or 28a-f shou ust be notified at	늄	10e. Street and Number 8416 Coco Rd.				10f. Zip Code 21237			10g. Citizen of What Counfry? USA		
urs after death with or thems 23a of Examples, must be	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, 2 Y No If Yes, Give 4 Year or Dates:				dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.) 2 No Specify:			o- 14. Race - American Indian, Bleck, White, etc. Specify: White		
thin 72 hou.	peteldu	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			16b. Kind of Business/Industry						
id be filed w ental Hygier had other th ic event, the	o Be Compl	0 0					Own Home rst, Middle, Meiden Sumame) h (unk.)				
nd 2 should sith and M. 27 to man's r traumed	-	19a. Informant's Name/Reletionship (Type, Print) John Lopata/husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 8416 Coco Rd. Baltimore, MD 21237									
Pages 1. ment of He ant: If Ben ury or oth		20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Gardens of Faith 20c. Location - City or Town, State 3-29-00 Baltimore, MD							(e		
Physician		21. Signature of Funeral Service Liganopes 22. Name end Address of Fecility 1211 Chesaco Ave. Rosedale Funeral Home Rosedale, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervel Between Onset and Death									
/Medical Examine	r	Immediate Couse (Finet disease or condition resulting in death) a. GCUTE myocardial Infarction Due to (or es a consequence of):									
an and rial-transit	Examiner	Sequentially list conditions. b. Colonic Infarction Due to (or es a consequence of):							4	Days	
2 2 2	edical	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last C. I. Schemic Coli + S. Due to (or as e consequence of):							Days		
a death cartificate the attending physical for use as the	Physician/M	Part II. Other significant conditions con	a. Intributing to death but not resulting	g in the underly	ing cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to the ca	use of death?	
aw requires that the second by a second by detact	þ	Preumonia Respiratory Failure					Yes 2 10	3 Probably			
	Completed					7	24a. Wes	s en autopsy ormed?	24b. Were auto aveilable p completion of death?	orior fo	
E 28	Be Co	25. Was case referred to medical axaminer?				26. Place of Dea		one)	1 ☐ Yes	2 No	
0 0	7	1 105 20,40		-	LAOO			idence 6 Oth			
leath. lost Affer the fune	Certification:	27. Manner of Death 1 Shatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	b. Time of finjury at Work? M 1 Yes 2 No		Yes 2 No	28d. Describe how injury occurre				
To the Hospital or Attand Within 24 hours after death To the Funeral Director: / completely filled in by the f		4 Homicide determined	building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Exami	ner: On the best of my knowled ner: On the basis of examinetion and mariner stated.	ige, death occu and/or investiga	ation, in my	opinion, deeth occur	and due to the rred at the time	, date and place,	and dua to the cau		
T T T T T T T T T T T T T T T T T T T	Σ	29b. Signature and title of certifier	A	1117	29c. Licen	se number		29d. Dete signe	d (Month, Day, Ye	ar)	

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State Registrar

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

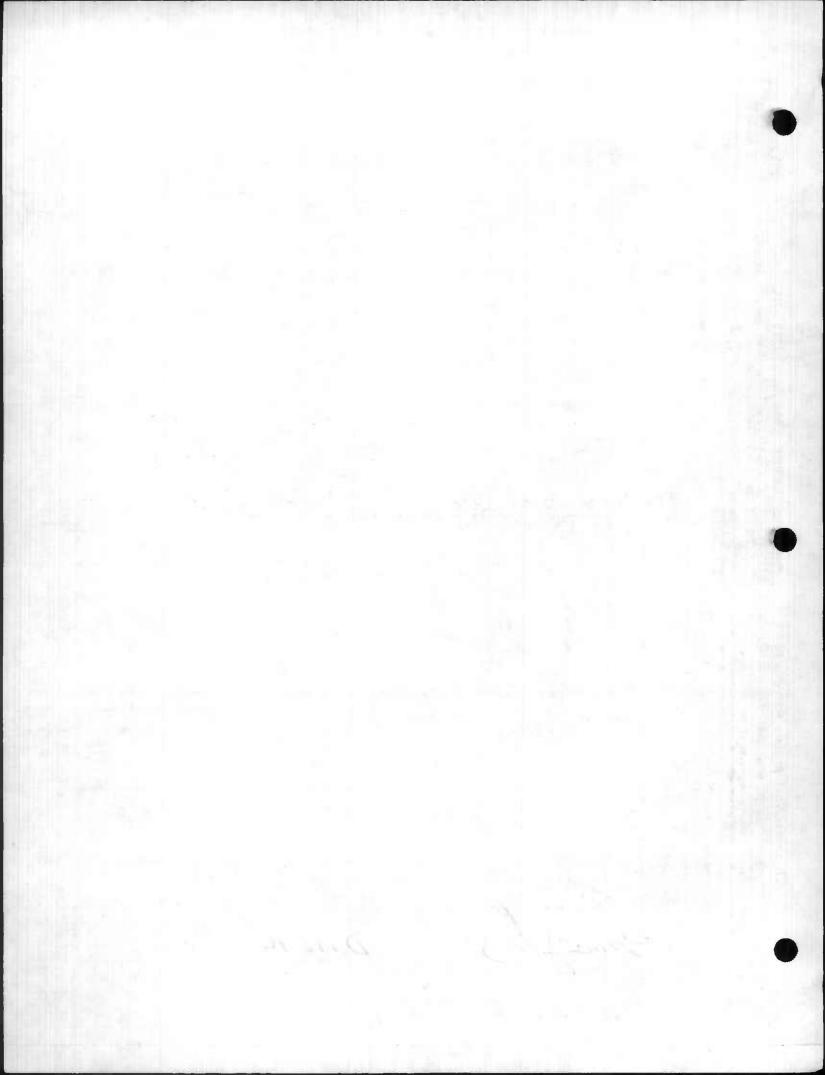
DR. Martin SHERIDan 9000 Franklin Square DR. Baltimore MD 21237

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

G. Spann



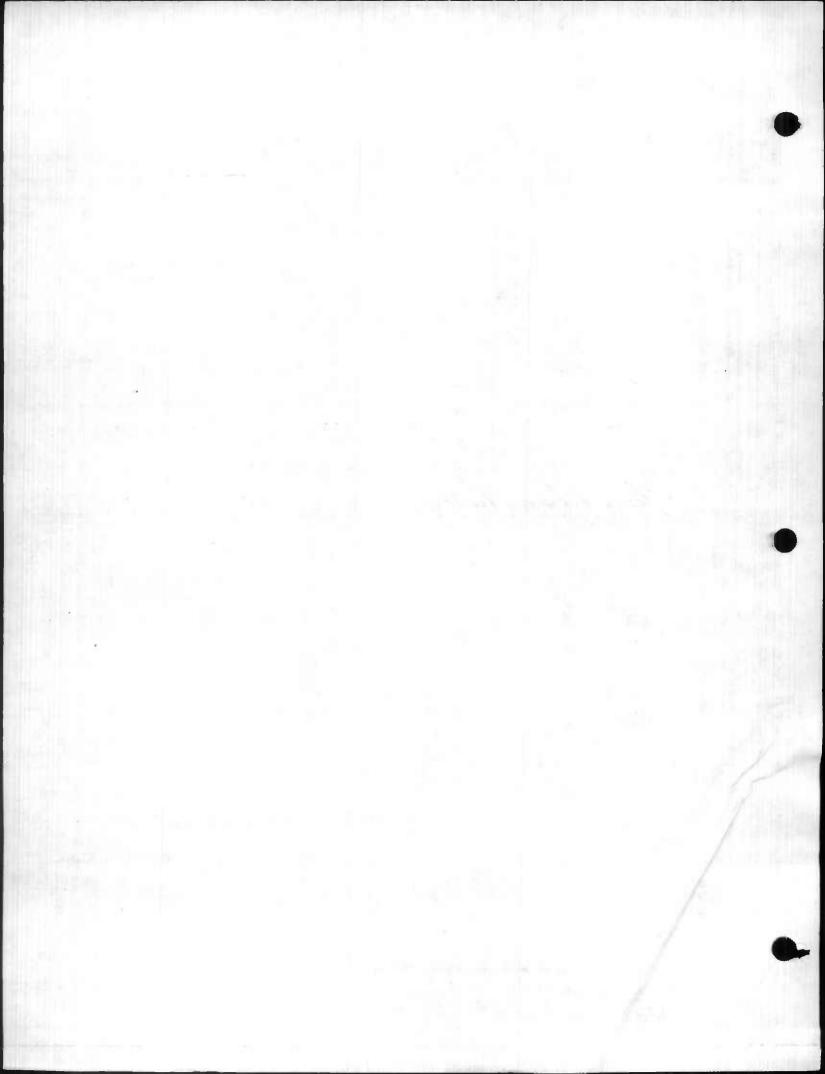
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** 150 Morris W. ARCH 2 2000 McCready /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris @ Mercy Hospice Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9/24 9. Birthplace (Stata or Foraign Country) **Funeral** Days Months Hours 12 M 2□F 72 27 220-18-9913 Director MD Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Nerna 23a or 28a-f show Director MD 1 □XYas 2 □ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2640 Ashland Avenue 21205 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. hours after 1 Never Married 2 Married b altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Baltimore Elamentary/Secondary (0-12) NA Collega (1-4or 5+) 10th Grade Laborer Santitation Dept. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Pages 1 and 2 should be nant of Health and Mental James 2 McCready Cora Johnson 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 21205 19a. Informant's Name/Ralationship (Type, Print) * important: If Item 27 any injury or other tr Kathleen McCready 2640 Ashland Avenue Baltimore, Maryland a of Disposition (Nama of Data 20c. Location - City or Town, State 20b. Piaca of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem. 03-30-2000 Owings Mill, 21. Signature of Funeral Sarvice License 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23 Part I. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart tailura. List only one causa on each line. Approximata Intarvai Batw Onset and Death **Physician** /Medical tmmediata Causa (Final Loma diseasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, py 3 Completed 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Dall 1 ☐ Yas 1 Yas 2 No Division of Vital 25 Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) STE //A 89 MARISAT MERCY Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) HOSDIC 10 1 Yas 2 No 2 ER/Outpatient 3 DOA 岩 28a. Data of Injury (Month, Day Year) Attact Certification: 27. Magnar of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Attending Natural 5 Panding death. 1 Yas 2 No Z Accident invastigation after death Director: 6 Could not be datarminad 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) È 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral C edical 29a. Certifier 11 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) NO 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) BAHIMORE, MD RISEDERG PAVID 21202

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 8 2000

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2. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 00-1649-510 State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #22 PER F.H. G781 3-28-2000 WR Certificate of Death Jeffrey McNair JVW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 22,2000 Jeffrey McNair 11:34 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Johns Hopkins Hospital Bal.timore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 F 219-92-9886 Yrs Director 20 Maryland 6 - 10 - 79Usual Residence of Decedent r 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2□No Baltimore Md. N-ADirector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be U.S.A. 21202 1024 Webb Court Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Meritel Stetus within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1⊠Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. UNK UNK 10th other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any linjury or other traumatic avant Rates. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ramona Ward Jeffrey McNair Sr. 19a. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 1024 Ward Court Baltimore, Md. 21202 Ramona Ward- Mother 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from Stete 3-29-2000 Maryland Voshell Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility 1639 NORTH BROADWAY BALTIMORE, MD 21213 Jeff Miller P.C. Funeral & Services 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between **Physician** ds of Chest Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner nding physician and use as the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificata be execu attending physician Box 68760 Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 94 signed by 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Page 2 has Yes 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 2 1⊠Xes 2□ No 1 ☐ Inpatient 3☐ ER/Outpatient 3☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of i or Attending P siter death. Certification: 1 Natural 5 Pending investigation 221 1 Yes 2 Accident 00 28f. Location (Street and Number or Rurel Route Number, City oppown, State) 6 Could not be 3 ☐ Suicide Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 900 BIK erss. Ga Te the Hospital (Ithin 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted. 29a. Certifier one) 29b. Signaly 29c. License number 29d. Dete signed (Month, Dey, Year) O.C.M.E. March 23,2000 30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print) Afon Locke ND 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Dey, Year)

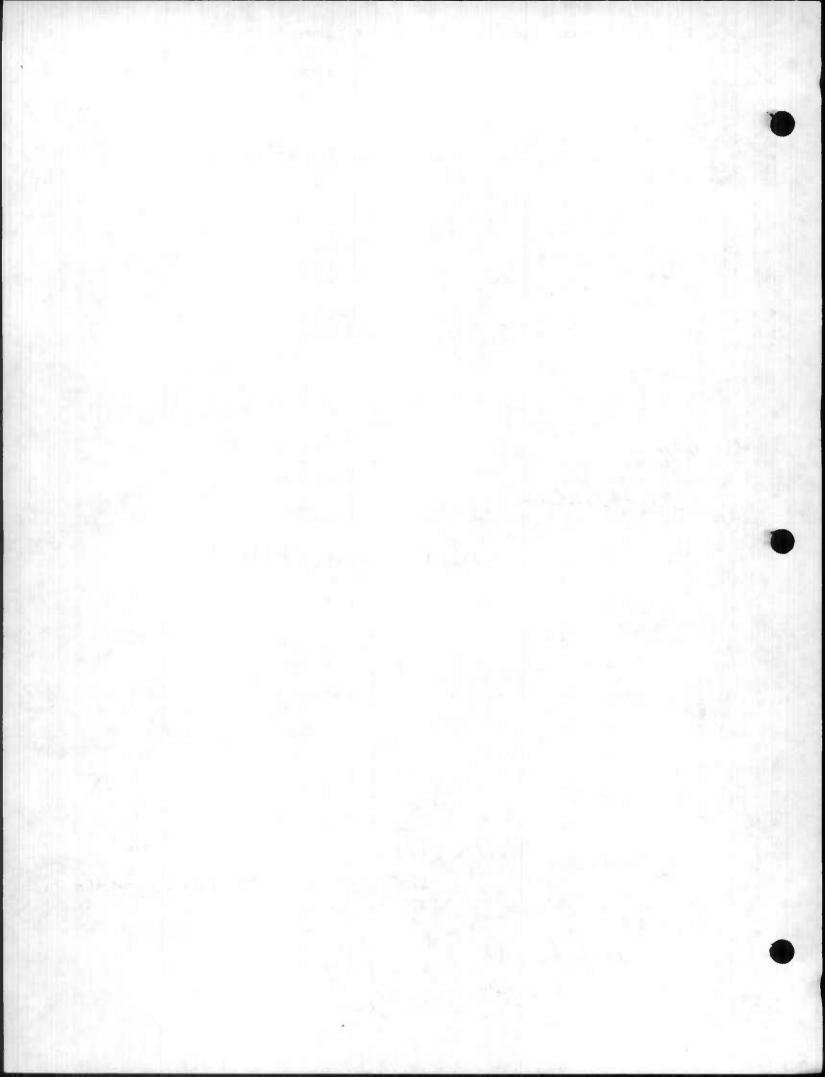
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State

Registrar

MAR 2 8 2000

32, Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth March **Physician** 00:03 2565 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Hopkins Hospital trove 0 MNS If Undar 24 Hrs. If Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number Dete of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 250-38-8809 Usual Residence of Decedent M 20 F Yrs. Director 411626,1928 SIC Pages 1 and 2 should be filed within 72 hours after death with the Maryland and cheath and Mental Hygiene. The filed 27 Is marked other than "natural", or hems 23e or 28e-f show my or other than the notified at my or other than matter notified at 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Ves 2 No Funeral Director BA ITO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 310 12. Wes Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No If Yes, Give Year or Dates: Air Force 14. Raca - American indian, 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) me)Annic unknoun KOBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shilah BAHO.MD. 212 24 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST VACON OWINGS 21. Signature of Furierat Service Licensee 22. Nama and Addrass of Facility BeTIS MARA St. by 10. md. alt AKOline 112911,0 23a. Part - Enter the caseage, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) Examiner Examiner 4 ECUS Hospital or Attending Physician: The law requires that the death certificate be executed Abouts after death. Funeral Director, After this certificate has been signed by the attending physician and telefy filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, ensu YEOVS Physician/Medical Due to (or as a consequence of) 10 years 1a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 40 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 25. Was case referred to medical examiner? 1 D yes 2 No 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manger of Death 26a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 26b Time of 5 Pending investigation Matural 1 Yes 2 No 2 Accident Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp Within 24 hor To the Fune completely fi (Check only one)

State Registrar

DHMH 16 Rev 6/95

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

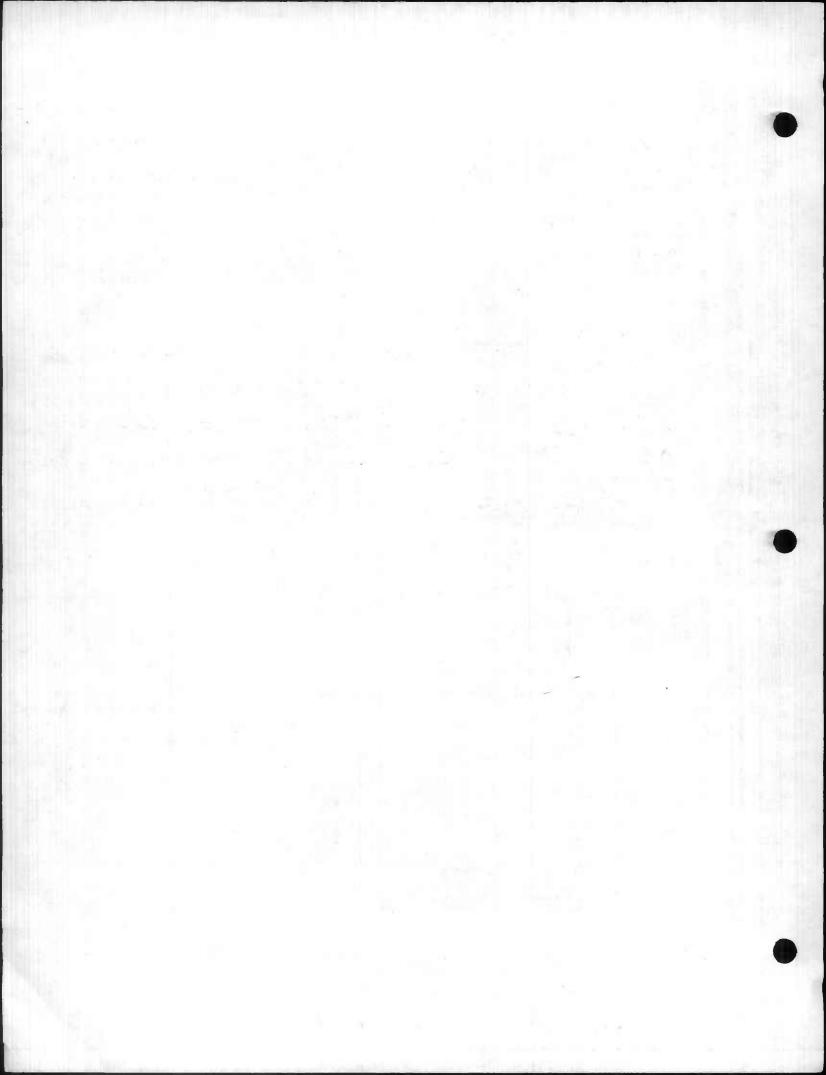
31. Data filed (Month, Day, Year)

32. Registrar's Signeture

ORIGINAL

29d. Date signed (Month, Day, Year)

Marking B-180 Borthmore MD 21287



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of Maryland / Department of Health and Mental Hygiene	00	0	9	9	9	6
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 03 Month Physician 23ay 12:20 P.M. Wilhelmenia Matthew /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Catonsville Commons If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) 12-20-1929 9. Birthplace (State or Foreign Country) South Carolina 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funeral Days 10M XXF 218-17-3205 Director Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYas 2 No N/A Md. Baltimore Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23a or 21229 USA 4541 Pen LUcy Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes & O.No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours aher Ospariment of Health and Mental Hyglacu. Important: If Item 27 is marked other than "natural", or its any injury or other traumatic event, the Medical Examina 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HomeMaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 88 Susan Bennett John Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4541 Pen Lucy Ave. Balto., Md. 21229 Murtis Stevenson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory 3/28/00 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Caple Funeral Service 13. 5502 Winner Ave. Balto., Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventphysician s the buriel Box 68760, Due to (or as a consequence of): signed by the e nt conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 20 No 3 Probably 4 Unknown Completed by 24b. Were autopsy lindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only

Registrar

Steven

Levenson M.D. 515 Fairmount Ave, 8 th Fl. Balto., Md. 21204 31. Date filed (Month, Day, Year) MAR 2 8 2000

and address of person who completed cause of death (Item 23a) (Type, Print)

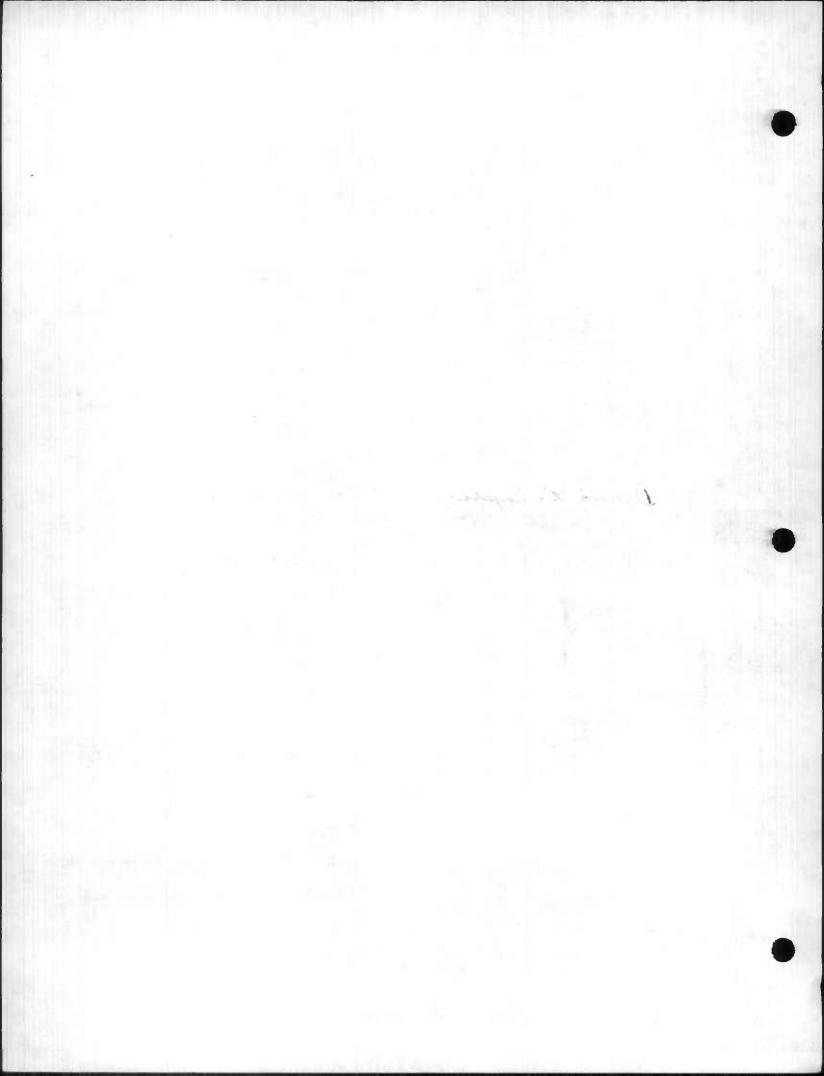
32. Registrar's Signature oaks

29c. License number

D18186

29d. Date signed (Month, Day, Year)

March 23, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

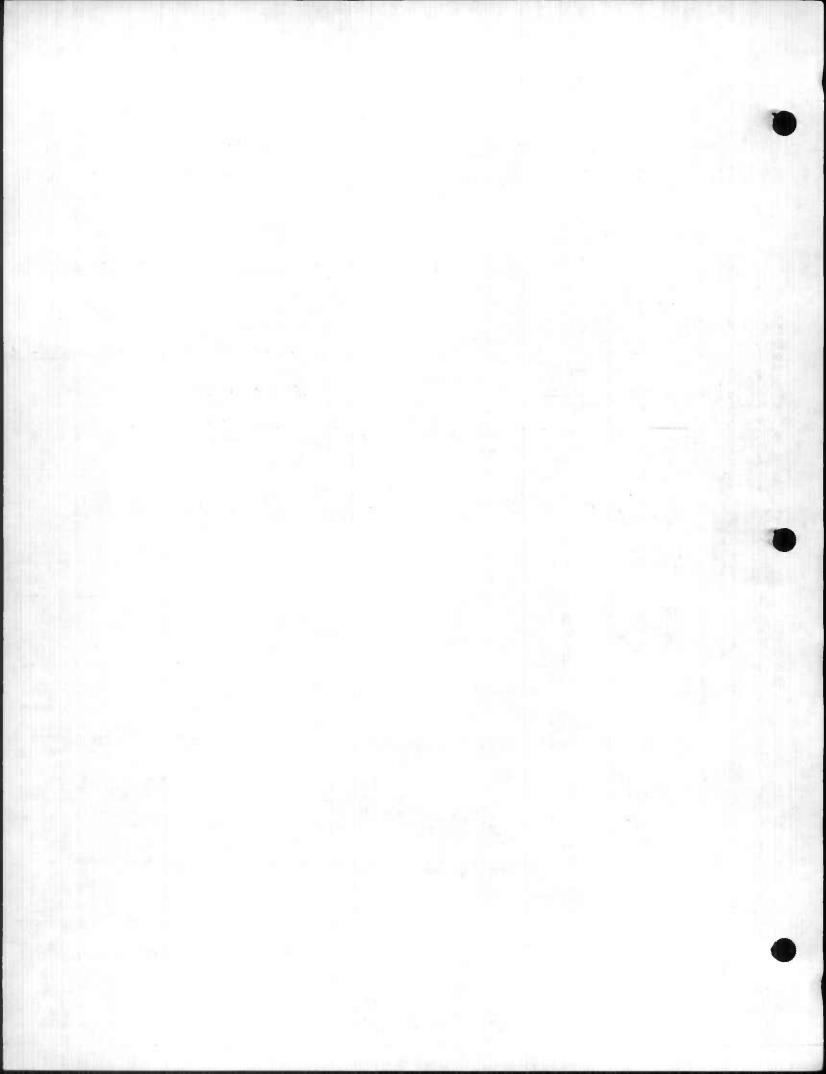
State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #19a PER FH G781 3/28/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Deeth 655 Month Vear Physician ARC 12,2000 AM McClendon /Medical Euletha 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Mercy Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1□M 2X)F Director 215-24-4385 05 08 28 S.C Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Nas 2□No Director 28a-1 MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Berns 23a Funeral 3404 Ingleside Ave 21215 U_S_A_ 14. Race - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes XIXNo If Yes, Give Year or Detes: 1 Never Merried 2 Married b Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à 3 Widowed 4 □ Divorced "natural". Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Food Service Worker Balto City Public Sch na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental ? 2 Huletha Hamilton Ardener Ingram 19a, Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.1 Department of Health ar Important: if Nem 27 is any Injury or other trau 4400 Wynfield Road, Owings Mills, Md Rick McClendon-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 3-28-00 Owings Mills, Md 21. Signature of Funeral Service License 22. Name end Address of Facility March F/H West 23a Part. Enter it e disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory errast, 21215 Approximata Intervat Between Onset and Death Physician tria /Medical Immediate Ceuse (Final disease or condition resulting to death) Examiner Dua to (or as a consequence of): Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): USB Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Unknown Records, à 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 2 NO 1 ☐ Yes 2 ☐ No certificata of Vital Be 25. Was case raferred to medical examiner? 26. Place of Death (Check only ona) STELLA MARIS AT MERCI 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) HOS DICE Certification: To 1 Inpatient 2 ER/Outpatienf 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Division After Attending 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fu 1 Yes 2 No 2 Accident investigation 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, sfreet, factory, office building, etc. (Specify) 4 ☐ Homicide 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) To the P within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ,2000 10 30. Name and eddrass of person who completed causa of death (Item 23a) (Type, Print) BALTIMORE MD21202 301 AUI KISE 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State WAR 28 Registrar 2000

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09994 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 7 2000 00:40NY 1AR /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE AGWES If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 89 Months Days Hours -18-464 1□M 2X F Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland 1 Yas 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or Nems 23s or 2229 ded Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Reca Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) American Indian, 11. Marital Stetus Bleck, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify PY African Department of Health and Mental Hygiene. Important: If Item 27 Is marked other tran "natural", any Injury or other traumatic avant, tra handers. 3 N Widowed 4 □ Divorced Year or Detas: Hmericar Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last, 18. Mother's Name (First, Middle, Meiden Sumame) Sou 101 19a. Informant's Neme/Reletionship (Type, Print) (Son) 19b. Meiling Address (Street and Number or Rural Route Number, atonsville Saw position (Name of remetory or other plece)

Bapt Church Cem.

22. Name and Address at Facility

Coph, L. Russ 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetery or other p 20c. Location - City or Town, State 1 Burlal 2 □ Cramation 3 □Removet from Stete 2000 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sertice Licer Funeral 1 Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear) feilure. List only one cause on each line. Md.21216 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting In death) HOURS /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably Whitnown þ 24b. Wera autopsy tindings aveilable prior to completion of cause of death? Completed TEOKRTHRITIS 24a. Wes an autopsy performed? NEUMONIA 1 Yes 1 □Yes 2 □ No Be 25. Wes cese referred to medical 26. Place of Death (Check only one) Hospitel: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → edical Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred Naturel 5 Pending investigation To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

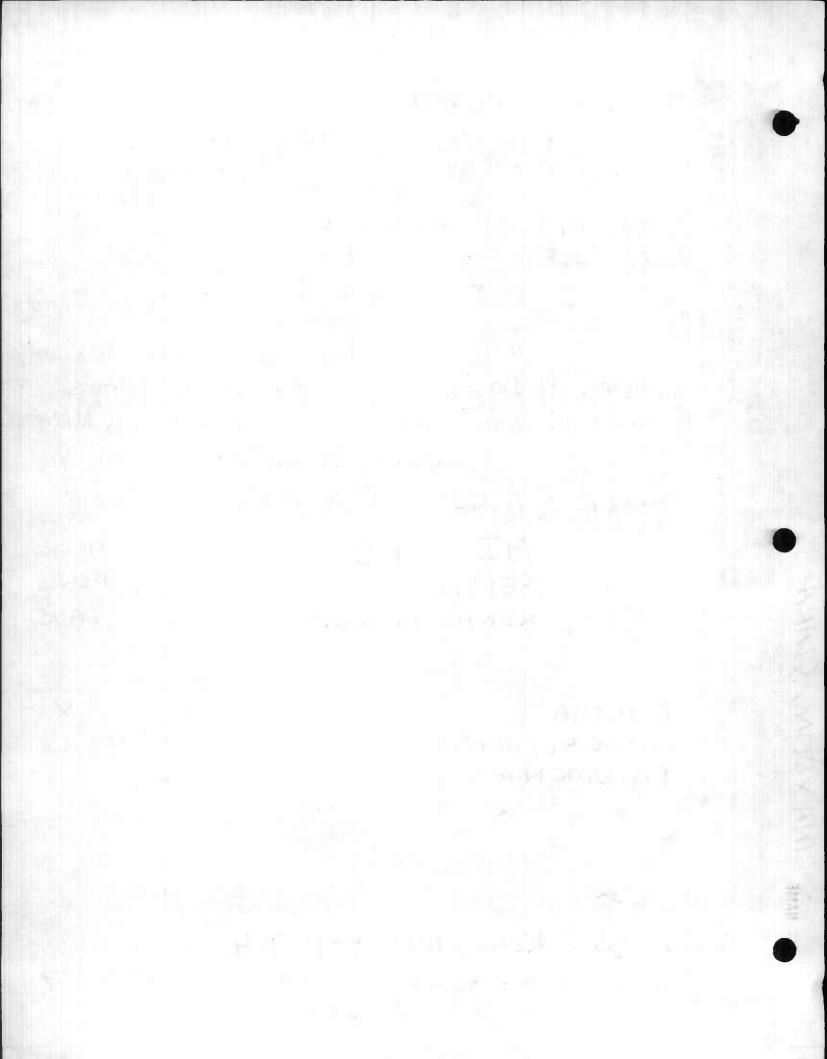
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31. Date tiled (Month, Day, Year)

MAR 28

32. Registrer's Signeture

900 CATON AVE BAUTIMORE, MD 2122



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year MOTT Bernice Louise March 2000 05:38A.M 501 22 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In)rs. last birthday) The Johns Hopkins Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Months Days Hours 1 M 2004 Yrs. 530-18-1470 69 Oct. Arizona Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 837 Reese Road 21144 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 224No Il Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas XXNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John Trammel Laura Ruth Manning 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Renda J. Morrison (Daughter) 837 Reese Road, Severn, MD 21144 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, cramatory or other place) Dafa 20c. Location - City or Town, Stata 1 ☐ Burial 2 ACramation 3 ☐ Removal from Stata 3/25 2000 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 rutta 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immedieta Causa (Final * Klspiration Lhours preumonio disaasa or condition rasulting in death) 3 weeks ballerema Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Cause (Disease or injury that initiated avents rasulting in death) Last Due to (or as a consequence of): Imonth 9 astroints hul Lleed Dua to (or as a consequence of): Dinbetes 10 years mellitins Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy tindings available prior to 24a. Was en autopsy performed? completion of cause of death? 1 TYes 2 No 1 ☐ Yes 2 No 25. Was casa rafarred to medical 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicida

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Examiner

altimore, Maryland 21215-0020

Box 68760. o Records, of Vital or Attending Physician: Division after death. Director: Aft filled in by 24 hours a Hospital completely To the Within 2

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signatura and fitla of certifiar

Simonson MD, 32. Registrar's Signatura MAR 2 8 2000 A A

smorrson 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

601 N Candine St Room 7413, Baltimore MD 21287

29c. License number

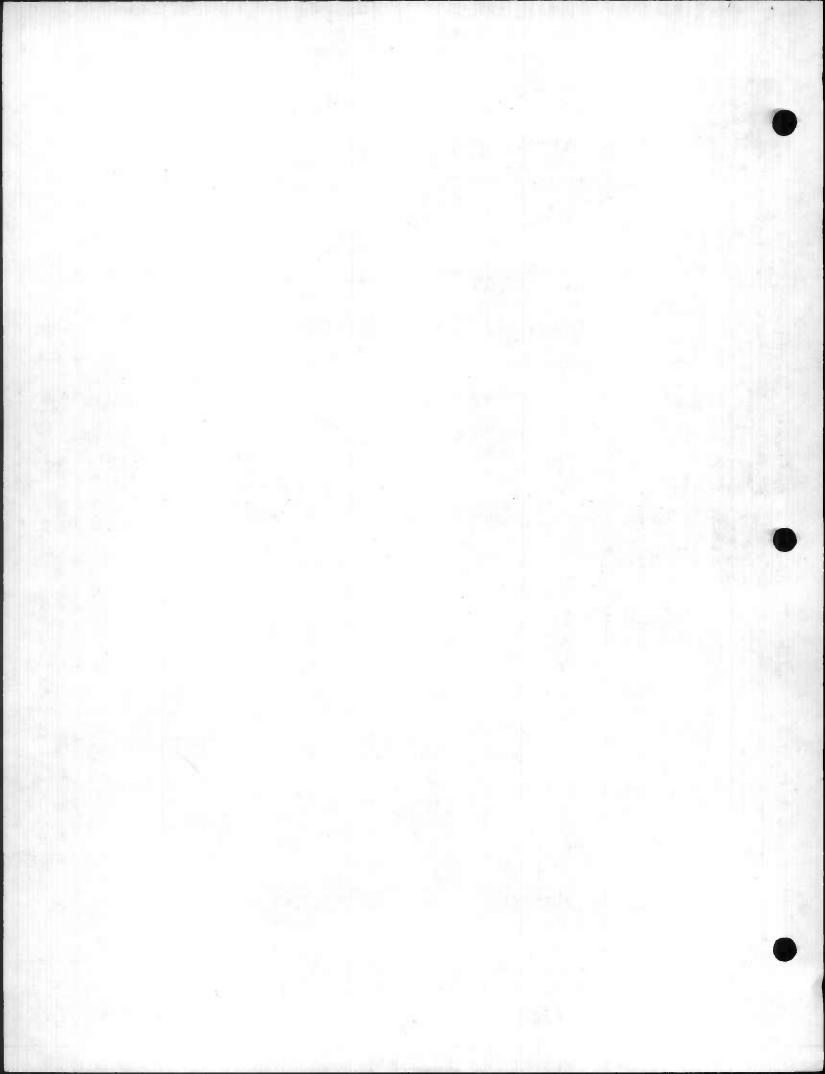
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ORIGINAL

1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mennar stafed. 29d. Data signed (Month, Day, Year)

3/22/00

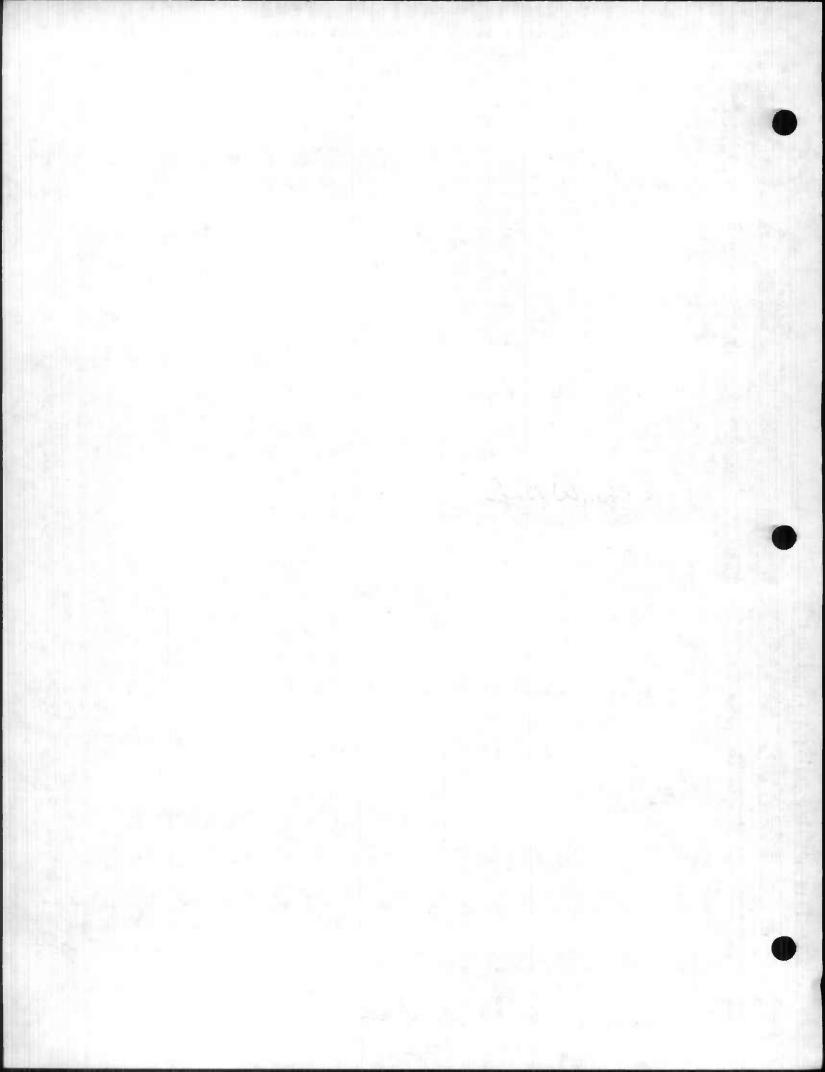


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 09996

	Certificate of Death		Reg. No.					
	Decedent's Name (First, Middle, Last)	2. Date of D	Death Day Yes	3. Time of Death				
Physicia Medica/	Madalana Nauman Marlana	MARCH	25 2000	2216				
Examine	4a Fecility Neme (If not Institution, give street and number) 4b. City, Town	n, or Location of Dea	ath 4c. County of D	eath				
	St. Agnes Hospital Balti							
Funeral Director	5. Social Security Number 212-03-6647 6. Sex 1 D M 2 XF 92 Yrs. Tunder 1 Year 1 Under 1 Year 2 Hours	Min. 8. Date of E (Month, I April	Birth (Pay, Year) 9. 1 6, 1907	Birthplace (State or Foreign Country) Maryland				
9 .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. fnside City Limits				
a or 28a-f show	MD D 1			1 ☑ Yes 2 ☐ No				
23a or 2	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4821 Williston Street 21229 U.S.A.							
	Baltimore 10e. Street and Number 4821 Williston Street 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: 1 Yes 2 No Fixed Forces? 1 Yes 2 No Fixed Forces For	n? (Specify Yes or P Puerto Rican, etc.)	No- 14. Race - A Black, W Specify:	merican Indian, Thite, etc. White				
		. dila	16b. Kind of Busine	ss/Industry				
6 9	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Long Distance Opera	ol working	9					
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d other event, 1	17. Father's Name (First, Middle, Last)	s Name (First, Midd	Aiddle, Maiden Sumame)					
Wann Info	John Wirts Emma	Neuman						
of Health and Mental H If them 27 is marked off or other traumatic even	19a. Informant's Name/Relationship (Type, Print) Dallas Currens (Daughter) 19b. Mailing Address (Street and Number 4901 St. Gemma Roa			e, Zip Code) 1229				
nent of He nt: If Nem rry or othe	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park 3/29/00 Elkridge, Maryland							
Department of important: If any injury or ance.	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228							
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as controls, or heart failure. List only one cause on each line.	ardiac or respiratory	errest,	Approximata Interval Between				
ertificate be ing physicia e as the bur	Immediate Cause (Final disease or condition resulting in death) a. G. J. Die to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of):	150						
the end of the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Di	23b. Did tobacco use contribute to the cause of death?					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	18	1 Yes 2 No 3 Probably 4 Unknown					
page 2 should be o	Coronary artery disease 24a. Was an autopsy performed? 24b.							
pag :	3	10	Yes 2 No	t ☐ Yes 2 ☐ No				
Section of	examiner?	of Deeth (Check only						
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s after death. All Directors After to ed in by the funers	2 Accident investigation 3 Suicide 5 Could not be determined 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)							
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To the	29b. Signature and title of cediffier. 29c. License number	29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year)						
You	Made The DJ12	56	March	25, 2000 Baltimore				
BI	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	allo U	_ A _	Rose				
0		1000	lon Duc	Dallmore				
State								

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** BEATRICE BERNICE MALONE MARCH 23 /Medical 2000 02:22 AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 24 Hrs BALTIMORE If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (tn yrs. last birthday) **Funeral** Months Deys Hours 1□ M XIX F Yrs Director 227-62-8457 JUL 15 1947 VIRGINIA **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1Kings 2 □ No Director notifie MARYLAND BALTIMORE CITY N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? r than "natural", or itema 23a or 702 PENNSYLVANIA AVENUE APT 4 21201 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. flied within 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Mever Married 2 Married 21215-0020 1 ☐ Yes 2 XXIvo Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 ahould be filled withir nent of Health and Mentel Hyglene. ant: If frem 27 is marked other than ury or other treumatic event, tha Mi Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A unknown Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL DUGGER MAMIE MALONE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Keith Collier/Brother 3957 RiverBluffs Pl. Richmond, Va 23223 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Daurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or page. 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 3-25-00 BALTIMORE, MARYLAND 21. Signature of Plan 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA Mollew 1206 W NORTH AVENUE 23a Proof Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, affect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** SEPSIS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner METASTAS IS The lew requires that the death certificate be assecuted attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): CANCOL Box 68760, Due to (or es a consequence of): algned by the attending of the detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 100 Certification: To 1 Phoatient 2□ ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Plasidence 6 □Other (Specify) this uneun 27. Manger of Death 1 @Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investiga Division or Attanding after deeth.

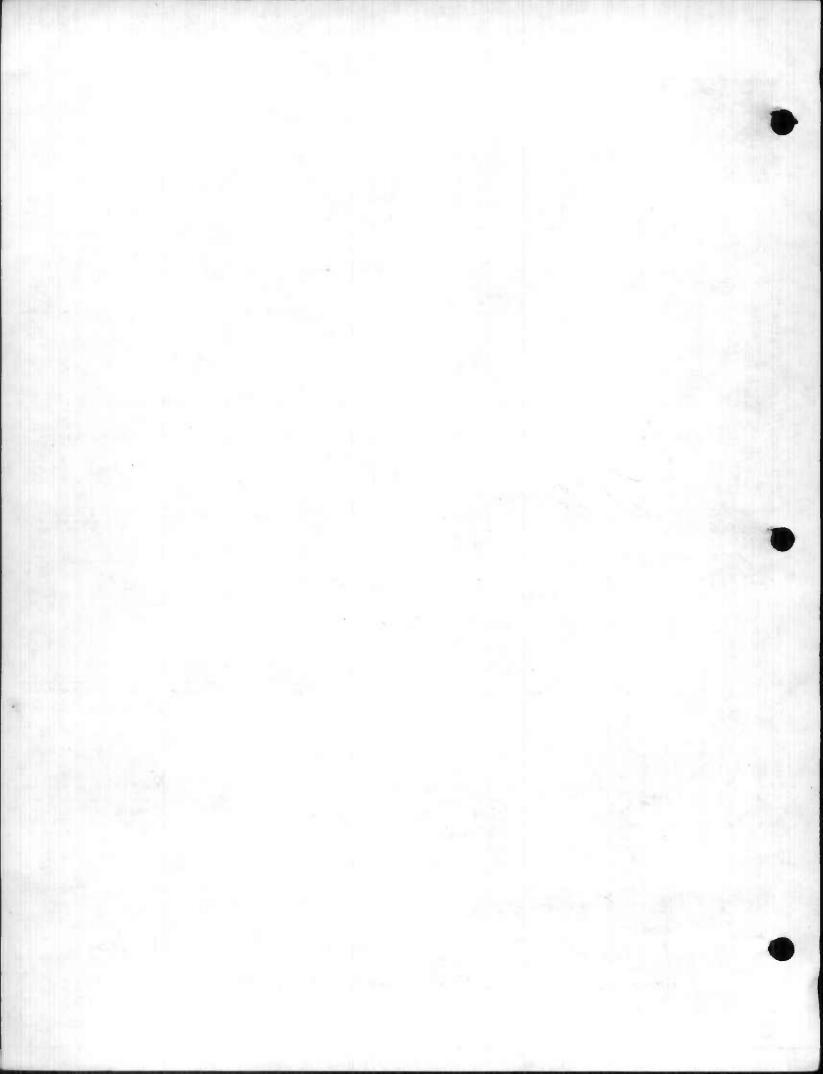
Director: Aft
d in by the fur 2 Accident 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Floute Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled In by 4 Homicide To the Hospital Within 24 hours To the Funerel C 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Menth, Day, Year) 027730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATAKIK NO LIZOY 6569 N. MARIET Cener 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAR 2 8 2000

was B. Anally



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MARY NORRIS 03 25 2000 7:50 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Joseph Nursing Home Catonsville Balto. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Days Yrs. 89 216-58-1228 Director 02/25/1911 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours after deepn with me new years at Hygiens.
I other than "naturel", or hems 23e or 28e-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Catonsville MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1322 Brook Rd. 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be liled. Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Emma Schleier 2 John Leahy 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21228 1322 Brook Rd. Barbara I. Norris Niece 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 Cremetion 3 ☐ Removel trom Stete Baltimore-Washington Crem 03/27 Laurel, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Furneral Service Ligar 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD. 21228 complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, ist only one cause on each line. Approximeta Interval Between Onset and Death **Physician** Corestine Ward Failure Immediate Cause (Final disease or condition resulting in death) /Medical year Examiner Due to (or as a consequence of) Examiner anding physician and use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Box 68760, Physician/Medical thet initiated events resulting in death) Last Due to (or es a consequence of) P.O. Part II. Other significant condifions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed bester Records, p 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate has 1 Yes 2 No 1 Yes 2 No Division of Vital 80 25. Was case reterred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Nature death. 1 | Yes 2 | No 2 Accident To the Hospital or Attended within 24 hours after death Testhe Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homleide 1 Hordifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. edical completely (Check only 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20, 2000 02478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

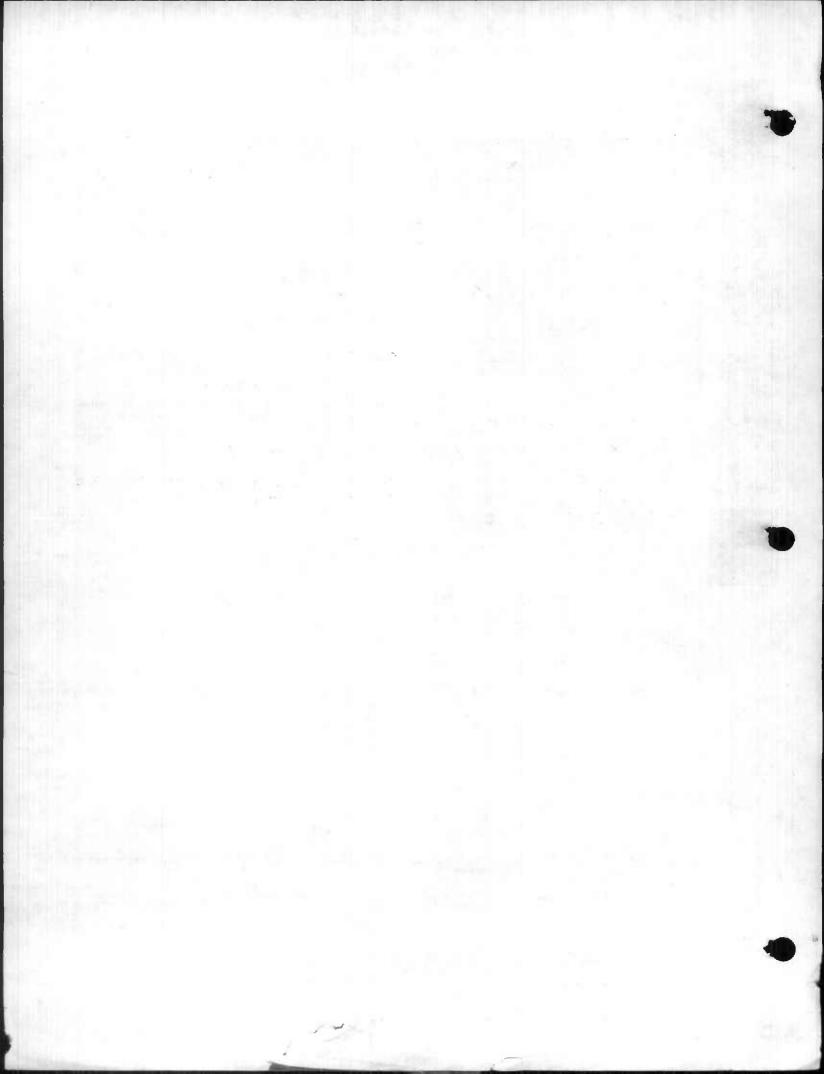
DHMH 16 Rev 6/95

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month Year MHO DLIVER 9:35AM MARCH 22 2000 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death BALTIMORE CITY NIA JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Days Hours Min. (Month, Day, Year) 6. Sex 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplace (Stata or Foreign Country) Days Months 38-6890 MD Usual Rasidence of Decedent 10d. Inside City Limits 10a Stata 10b County 10c. City, Town or Location 1 Yas 2 No MD NIA BALTIMORE 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 1434 AISQUITH STREET 21213 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yas, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Meritel Status 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega, (1-4or 5+) CITY OF BALTIMORE PUBLIC WORK 10 TH GRADE NA 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) JOHN OLIVER, SR CLARISSA TRUSTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 2906 E. FEDERAL JOAN KELLY SISTER ST. BALTO. MO. 21213 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Removal from Stata METRO CREMATORY 3.27-00 4 ☐ Donation 5 ☐ Other (Specify) BALTO. MO 21. Signetura of Funaral-Service Licensee 22. Nama and Addrass of Facility CREMATION SERVICES 5151 BALTO. NATL PIKE, BALTO, MO. CLU 23a. Part1. Enter the chaese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Intarval Between Onset and Death Immediate Causa (Finat HEMORRA 6JC disease or condition rasulting in death) ICONGULATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) MYOCARDIA ACUTE Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yaa 2□ No 3 Probably 4 Unknown A-IOS 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy ARYNGENC CANCER 1 Yas 2K No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ANatural
2 Accidant 5 Pending 1 Yas 2 No Investigation 3 Suicida

/Medical Examiner P.O. Box 68760. Records, of Vital or Attending Physician: this After Division within 24 hours after death. To the Funeral Director: A filled in by

Hospital

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Physician/Medical þ Completed Be

Examiner Medicai Certification: To

Physician

/Medical

Examiner

Funeral

Director

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Physician

Pages 1 and 2 should be

filed within 72 hours after

altimore, Maryland 21215-0020

Director

Funeral

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Completed

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25. Was casa rafarred to medical examinar? 1 Yas 2 No 27. Manpar of Death

6 Could not be

28a. Place of tnjury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the ceusa(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifias

4 Homicide

(Check only one)

29a, Certifier

hysichen 30. Nama and address of person who complated ceuse of death (Item 23a) (Type, Print)

1285-000

29c. License number

29d. Date signed (Month, Day, Year) MARCH 22, 2000

SACORS MISHELL, MD, 600 NORTH WOLFE ST, BALTIMORE, MD 31. Data filed (Month, Day, Year)

MAR 2 8 2000

32. Registrar's Signature

State Registrar

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F 1 1 11 14 11

DHMH 16 Rav 6/95

State

Registrar

29b. Signature and litle of certifier

MARYDMOD

31. Date filed (Month, Day, Year)

mel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

140254

32. Registrar's Signature

TAME

29c. License number

OCME

111 Penn Street, Baltimore, Maryland 21201

29d. Dala signed (Month, Dey, Year)

MARCH 24, 2000

